STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care Center	6000 E Iliff Ave 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)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on interviews and record review, the facility failed to provide person-centered, individualized recreational activities to meet the needs and interests, and promote physical, medical and psychosocial well-being for three (#3, #6, #8) three residents reviewed for activities out of eight sample residents. Specifically, the facility failed to provide one on one activity program visits to meet the individualized recreational needs of Resident #3, Resident #6 and Resident #8, who were identified by facility assessment and the resident's comprehensive care plans to need one on one activity visits. The findings include: I. Facility policy and procedure The Activities policy, dated 2017, was provided by the medical records director (MRD) on 6/11/24 at 4:05 p. m. It read in pertinent part, Philosophy: We believe the support and provision of leisure opportunities enhance the resident's quality of life. Physical, social, intellectual, psycho-social and spiritual opportunities provided to promote (the) highest practicable level of functioning. Leisure opportunities and interventions will be provided through individual and group activities to allow residents to utilize their abilities and for meeting their individualized needs and goals. Accountability: The activity director shall be responsible for the planning and implementation of the activity philosophy goals with the support of the staff and administration. The activity director is accountable to the resident for the appropriateness and quality of the individual plan and its execution. Objectives: To plan, organize and carry out a program of activities to meet the cultural, social, intellectual, physical, psychosocial and spiritual needs and interest(s) of the resident. To afford to the resident, personal enjoyment and satisfaction and to develop a feeling of usefulness and belonging. Support individual leisure choices respective to and expressed preferences. To encourage the development of new interests, hobbies and/or skills. To promote maintenance or enhancement of each resident's quality of life: dignity, self-determination and participation. (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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One to one: This term is used to indicate the time activity staff or volunteers spend with an individual resident. These sessions are geared to the functional level of the resident in order to meet needs in a way that is realistic. Examples of how time may be spent: stimulation with lotion, bright colors, textures or cloth, spices to smell, and music to move to or keep beat with. A visiting session over a cup of tea or coffee. Reading or listening to tapes. Playing games. Writing letters. Re-motivational cart or basket: these contain various tools for stimulating interest, combs, mirrors, scraps of material, pictures, colored paper and such. With such a cart or basket one can have what is needed in one to one sessions. II. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included anxiety disorder, unspecified dementia with agitation, cachexia (wasting or anorexia syndrome) and dorsalgia (pain in the back). The 4/9/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required maximum assistance with toileting, oral hygiene, bathing, and personal hygiene. The resident was frequently incontinent of urine and bowel. The assessment indicated the resident had delusions. The 10/5/23 MDS assessment revealed it was very important to Resident #3 to listen to music she liked, be around animals and keep up with the news. It was somewhat important for her to have books and have magazines or newspapers. B. Record review The comprehensive care plan, revised 10/23/23, documented Resident #3 enjoyed music, concerts, gardening, dancing and walking. She had a cactus collection at one time. She enjoyed having her mechanical cat with her. On 12/14/23 the care plan documented she was to receive and benefit from one on one activity visits two to three times per week. Review of Resident #3's leisure activity participation records for six months (from 1/1/24 to 6/9/24) revealed Resident #3 did not have any documented one to one visits from the activity department. C. Staff interview (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #1 was interviewed on 6/12/24 at 11:39 a.m. LPN #1 said Resident #3 had severe dementia and was difficult to redirect. She said Resident #3 often could not voice what she wanted. LPN #1 said the nursing staff tried to keep Resident #3 busy but it was difficult to do so. III. Resident #6 A. Resident status Resident #6, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included quadriplegia (paralysis of all four limbs), fusion of the spine cervical region, contractures of the right and left wrists, contracture of the left hand and hypertension (high blood pressure). The 3/27/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required maximum assistance with eating and oral hygiene. He was dependent on staff for toileting and showering. The 6/21/23 MDS admission assessment revealed it was very important to Resident #6 to keep up with the news. It was somewhat important for Resident #6 to have books or magazines to read, have visits with pets, go outside to get fresh air and to participate in religious activities. B. Record review The comprehensive care plan, initiated 7/5/23 and revised 9/9/23, revealed Resident #6 would benefit from one on one activity visits weekly from activity staff due to his quadriplegia. The activity staff might reminisce about his travels, family and discussion of current events. On 9/9/23 the care plan was revised to include Resident #6 was to receive one on one activity visits two to three times per week. The quarterly activity participation review on 4/2/24 documented the resident was receptive to receive one on one visits from the activity staff. C. Resident interview Resident #6 was interviewed on 6/13/24 at approximately 3:10 p.m. Resident #6 said he did not leave his room much. He said it had been exactly nine months and one week since he had attended a group activity. He said he did not receive one on one visits from the activity department. IV. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included cognitive communication deficit, chronic obstructive pulmonary disorder (COPD), dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body) and hypertension (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/11/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. She was dependent upon staff for oral hygiene, toileting, showering, personal hygiene and both upper and lower dressing. The 9/5/23 MDS admission assessment revealed it was very important to Resident #8 to keep up with the news. It was somewhat important for Resident #8 to have pet visits. B. Record review The comprehensive care plan, initiated 11/14/23, documented Resident #8 was to receive one on one visits from the activities department two to three times per week or as desired. The visits were to focus on leisure education and topics of interest, including playing games and in room bingo. The activity progress notes from January 2024 through June 2024 documented Resident #8 received two one on one activity visits during that time frame. One visit occurred on 1/3/24 and another visit occurred six months later on 6/9/24. The 3/15/24 quarterly participation review revealed Resident #8 was to continue on the one to one therapeutic visits program. V. Staff interviews and facility follow-up The AD was interviewed on 6/12/24 at 3:00 p.m. The AD said she had not documented one on one visits for Resident #3 because the visits were not completed. She said she did not have any documentation in her office or in the electronic medical records (EMR) that indicated she had done one on one activities with any residents. She said she knew that several residents had one on one activity visits in their care plans but the visits were not being completed. She said I have fallen short with this aspect. I can not provide proof of one on one visits for Resident #3 or for anyone in the facility because it has not happened for anyone. The AD said she did not know how to evaluate and determine who exactly should receive one on one visits from the activities department. She said she had the knowledge to know how to do a one on one visit but she was not doing it. The AD said she knew that a resident's comprehensive care plan needed to be followed. The AD said when care plans documented residents were to have one on one visits with activities, it should be done. The AD was interviewed again on 3/13/24 at 1:00 p.m. She said there were currently 17 residents who were supposed to receive one on one visits from the activities department. She said none of the 17 residents, including Resident #3, Resident #6 and Resident #8, had received one on one visits. The nursing home administrator (NHA) was interviewed on 6/13/24 at 3:30 p.m. The NHA said she was aware that one on one activity visits were not being done. The NHA said she spoke to the AD about getting inventive with activities. The NHA said she told the AD to have the activity assistant (AA) do the group activities with the residents and the AD do the one on one visits with the residents to ensure they were being completed. (continued on next page)

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