

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/21/2025
NAME OF PROVIDER OR SUPPLIER  Holly Heights Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>Based on record review and interviews, the facility failed to ensure money from personal funds account was managed accurately one (#110) of five residents reviewed for personal funds accounts out of 41 sample residents. Specifically, the facility failed to reimburse Resident #110's estate within 30 days from the resident's personal funds account after his death. Findings include: I. Resident 110's representative interview Resident #110's representative was interviewed on 8/20/25 at 12:46 p.m. He said he had opened a resident trust account on 12/20/24 at the facility. He said the resident passed away on 1/13/25, before any of the funds were used. The representative said he had left many voice messages for the facility's admission coordinator and left messages with the receptionist regarding the refund. Resident #110's representative was interviewed again on 8/21/25 at 11:46 a.m. The representative said he did not understand how the facility did not have his contact information since he was in communication with the nursing staff during Resident #110's stay. II. Record review The resident's admission agreement, dated 12/20/24 was signed by the Resident #110's representative. It revealed the resident's representative opened a resident fund on admission. The resident fund management service stated in pertinent part, In the event of my death, I redirect that any funds owed or advanced to me by the facility prior to my death are to be paid to the facility with any remaining balance in my resident fund account to become part of my estate. Review of Resident's #110's face sheet (form that contains pertinent information) revealed the incorrect phone number for the representative. -However, the admission agreement had the correct phone number and address. The electronic medical record did not reveal any documentation indicating that the facility had attempted to return the funds to the resident's estate or contact the resident's representative regarding the funds after the resident's death. III. Staff interview The business office manager (BOM) was interviewed on 8/20/25 at 11:05 a.m. The BOM said a resident's estate was reimbursed with remaining funds from a personal account after a death. He said Resident #110 did not open an account and would need to look into it. The BOM was interviewed on 8/20/25 at 12:00 p.m. The BOM said the resident did open an account and the facility would send a refund check to Resident #110's representative. The BOM was interviewed 8/21/25 at 1:00 p.m. He said the facility had not been able to get in touch with the representative after Resident #110's death. The BOM said the facility had sent a check to Resident #110's old address in hopes the family submitted a change of address card. The BOM said the check was returned to the facility and there was no further attempt to contact the representative.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in three of four shower rooms. Specifically, the facility failed to ensure shower rooms and tubs were clean and free from debris in order for residents to have a sanitary environment to bathe. Findings include:</p> <p>I. Observations On 8/18/25 at 1:35 p.m. the Summit Ridge unit shower rooms were inspected. The first shower room had empty shampoo and body wash bottles on the floor, along with piles of wet towels. The room had a smell of urine. The inside of the tub contained a bag of wet towels, two empty bottles and there was unidentified black grime and hair inside the tub. On 8/18/25 at 1:45 p.m. the Highline Creek unit shower room was inspected. The shower room had visibly dirty and wet towels on the floor. The inside of the tub contained wet towels, empty bottles and unidentified trash inside the tub. On 8/18/25 at 2:00 p.m. the Riverwalk unit shower room was inspected. The shower room was filled with resident equipment (wheelchairs, walkers and bedside commodes) with no access to the shower stall. II. Resident representative interview Resident #5's representative was interviewed on 8/19/25 at 3:42 p.m. The representative said one day she observed there was feces all over the floor in the shower room and in the shower and it smelled very bad. The representative said she had gone into the shower rooms before and had seen used towels on the floor and empty shampoo bottles. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/20/25 at 1:45 p.m. LPN #2 said the certified nurse aides (CNA) were to clean the shower rooms after each time the room was used. LPN #1 was interviewed on 8/20/25 at 1:51 p.m. LPN #1 said the CNAs were to clean the shower rooms at the end of their shift and the housekeepers deep cleaned the shower rooms weekly. CNA #3 was interviewed on 8/20/25 at 1:57 p.m. CNA #3 said the CNAs cleaned the shower rooms after using them and the housekeepers were supposed to clean the shower rooms weekly. The director of nursing (DON) was interviewed on 8/20/25 at approximately 2:30 p.m. The DON said that the facility was not currently using the tubs but he did not know why. He said if a resident asked to take a bath, first the CNAs would need to determine if a tub was working and then it would have to be cleaned. The DON said his expectation, regardless of if the tubs were working or not, was that the shower rooms were to be cleaned after every use and kept clean and disinfected for the residents by the CNAs.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in the main kitchen. Specifically, the facility failed to: -Utilize a pest control method that was sanitary; and, -Ensure perishable foods were labeled and dated. Findings include: I. Failure to utilize a method for pest control that was effective and sanitary A. Professional reference According to the Colorado Food Regulations (effective 3/16/24), retrieved on 8/28/25. Removing Dead or Trapped Birds, Insects, Rodents, and Other Pests. Dead or trapped birds, insects, rodents, and other pests shall be removed from control devices and the premises at a frequency that prevents their accumulation, decomposition, or the attraction of pests. (Chapter 6-501.112) B. Facility policy and procedure The Pest Control policy and procedure, revised 4/2021, was provided by the nursing home administrator (NHA) on 8/21/25 at 9:31 a.m. It revealed in pertinent part, It is the policy of the facility to provide an environment free of pests. Procedures to include; monitoring of the environment will be done by the facility staff. B. Observations On 8/18/25 at 8:45 a.m. during the initial walk through of the kitchen, a flat glue board pest trap approximately 7 inches by 4 inches was exposed and placed behind the steam table. The pest trap was more than 75% covered in various sizes of insects resembling cockroaches and within less than three feet of a gray tub that contained clean bowls. C. Record review A service report, dated 8/18/25 (during the survey), from the facility pest control company revealed the technician found dead German cockroaches, mice and spiders in the glue pest traps placed within the interior of the facility. D. Staff interviews The registered dietitian (RD) was interviewed on 8/18/25 at 9:00 a.m. She said she was not aware the glue pest trap was behind the kitchen equipment. The registered dietitian (RD) consultant was interviewed on 8/19/25 at 10:40 a.m. She said the facility kitchen staff did not put the exposed glue pest trap down, it was the facilities' pest control company that placed them. She said the facility kitchen staff were unaware the trap was there. She said the glue pest trap should not have been in proximity to the desert bowls. She said the desert bowls should have been covered and not exposed. The facility's pest control company was interviewed on 8/19/25 at 12:31 p.m. The exterminator said the facility contacted the company a month ago regarding seeing cockroaches in the open areas of the kitchen floors. He said he laid out approximately five to seven glue pest traps to determine the amount of roaches in the kitchen and potential areas of infestation. II. Failure to ensure perishable foods were labeled and dated. A. Professional reference According to the Colorado Retail Food Establishment Rules and Regulations (effective 3/16/24) retrieved 8/26/25 A date marking system that meets the criteria using a method approved by the Department for refrigerated, ready-to-eat, potentially hazardous food (time/temperature control for safety food) that is frequently re-wrapped, such as lunch meat or a roast. Marking the date or day of preparation with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Marking the date or day the original container is opened in a food establishment with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. Using calendar dates, days of the week, color coded marks or other effective marking methods. (Chapter 3-29) B. Observations On 8/18/25 at 8:45 a.m. during an initial kitchen tour, an unlabeled bowl with saran wrap over it in the walk in refrigerator that resembled coleslaw with a date of 8/16/25 and no label. On 8/18/25 at approximately 9:15 a.m. the Riverwalk nourishment refrigerator contained the following: an unidentified [NAME] jar with a pink substance, a store brand water bottle with an unidentified yellow liquid and four plates of different unlabeled foods with saran wrap over the plates. On 8/18/25 at 9:32 a.m., the Summit Creek nourishment refrigerator contained a bowl with a white creamy substance that resembled a salad dressing consistency and saran wrap over it without a label or date. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/20/25 at 1:51 p.m. She said the nurses and the certified nurse aides (CNA) were responsible for making sure items were labeled and not spoiled in the nourishment refrigerators. LPN #1 said if unlabeled or expired items were found, the nurses and CNAs should throw those items out. CNA #3 was interviewed on 8/20/25 at 1:57 p.m. She said it was part of the nightshift staff's responsibility to throw out unlabeled or spoiled items in the nourishment refrigerators. CNA #1 was interviewed on 8/20/25 at 2:02 p.m. She said it was part of the nightshift staff's responsibility to throw out unlabeled or spoiled items in the nourishment refrigerators. CNA #1 said if the day shift sees expired or unlabeled items, they should throw the items out and not wait for the night shift. The RD consultant was interviewed on 8/20/25 at 2:25 p.m. She said the kitchen staff were to check the nourishment refrigerators</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to provide a safe, sanitary, functional and comfortable environment for residents, staff and the public. Specifically the facility failed to:-Ensure necessary kitchen equipment was maintained in safe, working condition by repairing leaks to sinks timely; and,-Ensure handrails were in safe, operational, and functional conditions. Findings include:I. Failure to ensure kitchen equipment was maintained in safe and working conditionA. ObservationsOn 8/18/25 at 8:45 a. m. during the initial walk through of the kitchen, a P-trap (part of the pipe that is shaped like the letter P) pipe under the kitchen's handwashing sink was leaking water into a three gallon bucket, which was almost completely full.B. Staff interviewsDietary aide (DA) #1 was interviewed on 8/18/25 at 9:00 a.m. He said the handwashing sink had started leaking that same week. The maintenance director (MTD) was interviewed on 8/21/25 at 1:39 p.m. He said the handwashing sink in the kitchen started leaking several months ago and he noticed it was leaking into the subfloor. He said he replaced the P-trap pipe but it began leaking again a month ago. II. Failure to ensure handrails were in safe, operational, and functional conditions. A. ObservationsOn 8/18/25 at approximately 9:30 a.m. during an initial walk through, the following was observed:There was gray electrical tape covered the center portions and the curved, connecting sections attaching the hand railings to the wall by room [ROOM NUMBER], #8, #11 and #58. There was gray electrical tape and yellow caution tape on the curved, connecting section attaching the handrailing to the wall outside of room [ROOM NUMBER] was observed;The hand railings were cracked with exposed sharp edges in the center sections and the curved, connecting sections attaching the handrailing to the wall on the handrails outside of the business office and outside of room [ROOM NUMBER]; and, The handrail was missing the curved, connecting section attaching the handrailing to the wall outside of room [ROOM NUMBER].B. Staff interviewsThe MTD was interviewed on 8/21/25 at 1:39 p.m. He said he was unsure how long the handrails had been damaged. He said it had been an ongoing problem trying to repair the handrails because the residents bumped into handrails and broke the railings. He said the damaged handrails created a hazard for the residents.</p>		