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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to inform residents about hospice care before notifying a hospice agency for four (#3, #8, #9 and #7) of seven residents out of 10 sample residents.Specifically, the facility failed to inform Resident #3, Resident #8, Resident #9 and Resident #7 in advance of proposed treatment options by a physician or other healthcare professional prior to sharing their information with a hospice company. Findings include:I. Facility policy and procedureThe Resident Rights policy, revised April 2022, was provided by the nursing home administrator (NHA) on 12/4/25 at 5:43 p.m. It read in pertinent part, To be fully informed in advance about care and treatment, and, unless adjudicated incompetent or otherwise found incapacitated under state law, participate in planning medical treatment. To be fully informed in a language he or she understands of his or her medical condition and health status.II. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician's orders (CPO), diagnoses included polyneuropathy, muscle weakness, dementia, morbid obesity and violent behavior.The 11/19/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15.B. Record reviewReview of the December 2025 CPO revealed no physician's orders or evaluations for hospice services.Review of the comprehensive care plan did not reveal the resident was receiving hospice services or desired hospice services. Review Resident #3's electronic medical record (EMR) did not reveal documentation indicating the facility had a conversation with the resident's power of attorney (POA) or private-hire case worker about hospice services.C. Resident #3's representatives interviewResident #3's private case worker was interviewed on 12/4/25 at 10:00 a.m. The case worker said Resident #3's POA was contacted on 10/16/25 by the hospice director. The case worker said neither Resident #3's POA nor the case worker had discussed hospice services with the facility. The case worker said the hospice director had received Resident #3's information from the facility and wanted to determine if Resident #3 wanted hospice services. The caseworker said the POA was concerned about this phone call and thought someone was trying to take advantage of Resident #3. The caseworker said the POA asked the case worker to investigate the situation because she believed Resident #3 might be in danger.Resident #3's POA was interviewed on 12/4/25 at 12:42 p.m. Resident #3's POA said she never had a conversation with the facility about initiating hospice prior to the phone call from the hospice director. Resident #3's POA said the phone call from the hospice director disturbed her. She said she thought Resident #3's safety was at risk. She said she thought someone had stolen Resident #3's information and was trying to financially abuse her. III. Resident #8A. Resident statusResident #8, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included acute and chronic respiratory failure, congestive heart failure, sequelae of cerebral infarction, and type 2 diabetes.The 11/10/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of six out of 15.B. Record reviewThe 10/20/25 social services progress note documented the resident was admitted to hospice on 10/20/25. Review of Resident #8's EMR did not reveal documentation indicating the facility had spoken with Resident #8 or his family regarding hospice services prior to 10/20/25.C. Resident #8's POA interviewsResident #8's POA was interviewed on 12/4/25 at 12:58 p.m. The POA said she had not discussed hospice care with the facility before the hospice agency had contacted her. She felt freaked out because the hospice agency knew how to contact her. She said it had upset her further because end-of-life care was a delicate subject, and the conversation was unexpected.IV. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included dementia, hypothyroidism, and chronic kidney disease.The 10/22/25 MDS assessment revealed Resident #9 had severe cognitive impairments through staff assessment.B. Record reviewThe 10/27/25 social services progress note documented the hospice agency would evaluate Resident #9 for hospice criteria. The note documented the hospice agency had already spoken with Resident #9's POA about enrolling in hospice.Review of Resident #9's EMR did not reveal documentation that the facility spoke to Resident #9 or her POA about hospice care.C. Resident #9's POA interviewResident #9's POA was interviewed on 12/4/25 at 3:22 p.m. The POA said the hospice agency had called her in late October 2025. She said it was a mystery how the hospice agency got her contact information because she had never discussed hospice with the facility prior to the phone call. The POA said Resident #9 was enrolled in hospice services.V. Resident #7A. Resident statusResident #7, age greater than