STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for two (#2 and #3) of eight residents out of 15 sample residents. Specifically, the facility failed to complete a thorough investigation after an allegation of physical abuse towards Resident #3 by Resident #2. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised January 2025, was provided by the nursing home administrator (NHA) on 5/21/25 at 11:30 a.m. The policy read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation and misappropriation of property or resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation, investigating different types of alleged violations, identifying and interviewing all involved persons including that alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations, focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and the cause, and providing complete and thorough documentation of the investigation. II. Incident of physical abuse of Resident #3 by Resident #2 A. Facility investigation (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/10/25 facility investigation was provided by the director of nursing (DON) on 5/22/25 at 12:00 p.m. The incident report revealed Resident #2 had combative behaviors during care toward staff on 4/6/25. When Resident #2 was in the dining room, he was offered snacks by activities assistant (AA) #1 at approximately 10:30 a.m. Resident #2 started to throw items off the table and splashed his cup of coffee across the table where other residents were sitting nearby. Resident #2 was immediately removed from the dining room and was redirected to his room with a certified nurse aide (CNA). He was placed on one to-one supervision with a CNA in his room where he was easily redirectable and exhibited no such behaviors afterwards. -Review of the facility's investigation did not identify the coffee was thrown towards Resident #3, however, licensed practical nurse (LPN) #1 said Resident #2 threw the coffee at Resident #3 (see interview below). The investigation documented Resident #2 was interviewed on 4/7/25 and did not recall the incident from the day prior. He was in a pleasant mood and away from other residents in the common area. The investigation documented Resident #3 was interviewed on 4/7/25 and appeared to have no recall of an incident occurring the day prior. The investigation documented five additional residents on the secured unit were interviewed by the DON on 4/7/25 with no additional information. The investigation documented five additional staff interviews (LPN #2, LPN #3, LPN #4, CNA #2 and CNA #3) were completed on 4/7/25 by the DON with no additional information. -LPN #2, LPN #3, LPN #4, CNA #2 and CNA #3 typically worked on the secured unit, but were not present during the 4/6/25 altercation. The investigation documented AA #1, who witnessed the incident, was interviewed on 4/7/25 by the DON. AA #1 said she was in the dining room during the coffee social in the secured unit when Resident #2 was being disruptive and attempting to throw items off the table. Resident #2 threw his coffee towards an area where other residents were sitting. AA #1 said the assistant director of nursing (ADON) was notified. AA #1 said another CNA took Resident #2 out of the dining room area and redirected him back to his room. B. Resident #3 (victim) 1. Resident status Resident #3, age 66, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included dementia, alcohol abuse and history of falling. The 4/7/25 minimum data set (MDS) assessment documented Resident #3 had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out 15. He required supervision with activities of daily living (ADLs). The MDS assessment indicated Resident #3 did not exhibit verbal, physical or other behavioral symptoms directed towards others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review The 4/7/25 alert note documented Resident #3 was being monitored after a resident-to-resident altercation. Resident #3 was alert to self and his needs were anticipated by staff. It documented Resident #3 was compliant with care, showed no signs or symptoms of pain or discomfort and there were no behaviors reported. C. Resident #2 (assailant) 1. Resident status Resident #2, age 76, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included vascular dementia and type two diabetes. The 5/9/25 MDS assessment documented Resident #2 had moderate cognitive impairments with a BIMS score of eight out 15. He required supervision for ADLs. The MDS assessment indicated Resident #2 did not exhibit verbal, physical or other behavioral symptoms directed towards others. 2. Record review The 4/6/25 behavior charting note revealed Resident #2 was reported to have combative behavior towards staff members. When Resident #2 was in the dining room, he was disruptive and was seen throwing his cup of coffee where other residents were sitting. Resident #2 was immediately removed from the dining room away from other residents. III. Staff interviews The pulmonary program coordinator was interviewed on 5/22/25 at 11:22 a.m. The pulmonary program coordinator said he was working in the secured unit on 4/6/25. The pulmonary program coordinator said he witnessed an incident between Resident #2 and Resident #3 on 4/6/25. The pulmonary program coordinator said Resident #2 had a cup of coffee and Resident #2 threw his cup of coffee in the area of Resident #3, who was seated at a different table. The pulmonary program coordinator said he wrote a statement about the incident between Resident #2 and Resident #3 on 4/6/25 and gave the statement to the DON. -However, review of the facility's investigation did not include documentation that the pulmonary program coordinator provided a statement (see facility investigation above). The pulmonary program coordinator said LPN #1 assessed Resident #3 after the incident on 4/6/25. The pulmonary program coordinator said the ADON was called and the ADON came to the secured unit to assess the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 5/22/25 at 12:41 p.m. LPN #1 said she was working on the secured unit on 4/6/25. She said there was an activity going on in the unit around 10:30 a.m. She said AA #1 was handing out coffee to the residents in the dining room area. She said Resident #2 was sitting across the table from Resident #3. She said Resident #2 looked at Resident #3 and threw his cup of coffee at him unprompted. She said she immediately notified the ADON who was in the building in another unit. She said she separated Resident #2 and Resident #3. She said she took Resident #3 to his room to complete a skin assessment. She said the ADON assisted her in the skin assessment. She said there were no skin alterations but she put damp towels on Resident #3's skin in case there was burning. She said she communicated the allegations of abuse to the ADON because he was the manager there and she was a mandatory reporter. LPN #1 said the ADON called the DON and then handed the phone to LPN #1. LPN #1 said she told the DON what happened and said the DON instructed her to fill out the first page of the risk management note which included a summary of what happened, the resident's description of what happened, and immediate action that was taken, which included the skin assessment she completed. She said she asked the DON if there was anything more she needed to do and the DON said she would take care of it. She said the DON said she would fill out the rest of the risk management note and notify the police. She said about an hour later, she sent a text message to the ADON verifying that the DON would take care of notifying the police and filling out the rest of the risk management note. She said the DON told her not to write a nursing progress note about the incident. She said nobody attempted to reach out to her regarding the situation. She said when she came back to work the following Sunday (4/13/25), the risk management note was no longer in the medical charts and there was no note under either resident's progress notes about the incident. -Review of the facility's investigation did not include documentation that LPN #1, who witnessed the resident-to-resident altercation, was interviewed during the investigation process (see facility investigation above). The ADON, the DON and the NHA were interviewed together on 5/22/25 at 1:00 p.m. The ADON said he was working on 4/6/25 and staff in the secured unit called him. The ADON said he went to the secure unit after Resident #2 threw his coffee. The ADON said he was notified there was an incident because he was a manager and was told it was a behavior issue. The ADON said he assigned a restorative aide to provide one-to-one supervision after the incident. The ADON said when he arrived in the secured unit, Resident #2 was not having any behavior issues. The DON said she was not working on 4/6/25 when Resident #2 threw his coffee. The DON said the ADON called her to inform her Resident #2 was having behaviors. The DON said the ADON told her the resident was throwing coffee. The DON said she instructed the ADON to remove the resident from the activity that was occurring. The DON said she came into the facility on Monday (4/7/25) to do the investigation. The DON said Resident #2 had splashed his coffee across the room. The DON said none of her interviews revealed that Resident #2 threw his coffee at Resident #3. The DON said she called LPN #1 about the incident but LPN #1 did not call her back. The DON said LPN #1 only worked on Sundays at the facility. The DON said she did not attempt to interview LPN #1 again. The DON said she did not have a statement provided by the pulmonary program coordinator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON and the NHA were interviewed together on 5/22/25 at 2:52 p.m. The DON said she wanted to investigate to see if there was any harm involved from the behavior Resident #2 exhibited. She said when Resident #2's behavior occurred on 4/6/25, it was one of her first weeks as the DON. The DON said since the behavior Resident #2 had was not new behavior, she decided to interview other residents and ask if they were in distress or remembered the incident. The DON said she provided verbal education with the nursing staff on 4/7/25 regarding behavior charting and how to document it. The NHA said he was the abuse coordinator and he found out about the incident between Resident #2 and Resident #3 on 4/7/25. The NHA said the facility did not complete a thorough investigation to determine if Resident #2 throwing his coffee was a behavior or an abuse incident. He said the facility should have completed staff interviews with all staff in the secured unit during the time this occurred. He said he thought since there were a lot of behaviors that occurred on the memory care unit, it was not communicated to the DON as abuse but rather as a behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 47151 Based on observations, record review and interviews, the facility failed to provide each resident with a nourishing, palatable and well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences. Specifically, the facility failed to ensure weekly menus were balanced and included a variety of menu items. Findings include: I. Resident interviews Resident #4 was interviewed on 5/21/25 at 11:18 a.m. Resident #4 said she wished the menu had better variety and the menu options changed more frequently. Resident #4 said lately the menu was too repetitive and there was too much chicken and pork on the menu. Resident #8 was interviewed on 5/21/25 at 3:55 p.m. Resident #8 said the menus were too repetitive. Resident #8 said the vegetable options on the menu were too repetitive. Resident #8 said there were too many vegetable blends and mixed vegetables on the menu. Resident #15 was interviewed on 5/21/25 at 4:10 p.m. Resident #15 said at times the menu was too repetitive. II. Weekly menu Four weeks of menus were provided by the nursing home administrator (NHA) on 5/22/25 at 2:42 p.m. A review of the four week menu (served during the survey) revealed repeated menu items. Vegetables, vegetable blends, chicken, pork, potatoes and rice were items repeated on the weekly menu. The menu reviewed for the week of 4/28/25 to 5/4/25 revealed the following: -On 4/29/25 the dinner vegetable was mixed vegetables; -On 4/30/25 the lunch vegetable was vegetables; -On 5/1/25 the lunch vegetable was mixed vegetables; -On 5/3/25 the lunch vegetable was seasoned vegetables; and, -On 5/4/25 the lunch vegetable was mixed vegetables. The menu reviewed for the week of 5/5/25 to 5/10/25 revealed the following: -On 5/5/25 lunch was chicken fajitas and red rice; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 5/6/25 the lunch vegetable was seasoned vegetables; -On 5/6/25 the dinner vegetable was vegetables; -On 5/7/25 the lunch was sweet and sour chicken, steamed rice and vegetables; -On 5/8/25 the lunch was a barbecue chicken breast and vegetables; -On 5/9/25 the lunch vegetable was mixed vegetables; -On 5/9/25 the dinner entree was a chicken sandwich; -On 5/10/25 the dinner vegetable was vegetables; and, -On 5/11/25 the lunch vegetable was seasoned vegetables. The menu reviewed for the week of 5/12/25 to 5/18/25 revealed the following: -On 5/13/25 the lunch vegetable was vegetables; -On 5/13/25 the dinner vegetable was mixed vegetables; -On 5/14/25 the lunch vegetable was vegetables; -On 5/15/25 the lunch vegetable was mixed vegetables; -On 5/15/25 the dinner vegetable was vegetables; and, -On 5/16/25 the lunch vegetable was seasoned vegetables. The menu reviewed for the week of 5/19/25 to 5/25/25 revealed the following: -On 5/19/25 the dinner was a crispy chicken wrap; -On 5/20/25 the lunch was a creamy chicken breast, pasta (penne) and seasoned vegetables; -On 5/20/25 the dinner was pasta (egg noodles) and seasoned vegetables; -On 5/21/25 the lunch was pineapple barbecue chicken thigh; -On 5/22/25 the lunch was slow roast pork loin and seasoned vegetables; -On 5/22/25 the dinner was chicken fajitas; -On 5/23/25 the lunch vegetable was mixed vegetables; -On 5/24/25 the lunch was roast pork loin with scalloped potatoes; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 5/24/25 the dinner was grilled chicken with gravy creamy mashed potatoes and vegetables; -On 5/25/25 the lunch was baked ham with baked sweet potato and seasoned vegetables; and, -On 5/25/25 the dinner was slow roast pork loin, roasted potatoes and vegetables. III. Staff interviews The dietary manager (DM) was interviewed on 5/22/25 at 10:30 a.m. The DM said she could change the menu at the facility and she could choose which options to place on the weekly menu. The DM said the areas she needed to work on at the facility when she arrived four months ago was menu choices and food quality. The DM said the residents used to receive one kind of mixed vegetable blend every day and the residents wanted more variety of vegetables. The DM said specific vegetables she ordered would not be delivered. She said if she ordered five kinds of vegetables during the week the vegetables would not be delivered and she would go to purchase vegetables at the store. The DM said when the menu said' vegetables' the cooks received verbal instruction on which vegetable to make. The DM residents have said to her,' oh pork again what can I have instead?' The DM said residents could order a variety of items such as chicken breasts, chicken tenders and a beef patty. The DM said these items were not listed on the alternate menu. The nursing home administrator (NHA) was interviewed on 5/22/25 at 10:30 a.m. The NHA said facility employees brought residents menus so residents could choose what they wanted at meal time. The NHA said he did not know how the residents knew what vegetable was being served each day when the menu offered ' vegetables.'