STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Care & Rehabilitation LLC	3131 S Federal Blvd Denver, CO 80236

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 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. (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
	065191	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Care & Rehabilitation LLC	3131 S Federal Blvd Denver, CO 80236

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#1) of four residents received adequate supervision to prevent accidents out of four sample residents.Specifically, the facility failed to ensure staff did not leave Resident #1, who had a history of falls and required maximal assistance with showering, alone in the shower room during her showers.Findings include:I. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included paraplegia, type 2 diabetes mellitus, muscle weakness, major depressive disorder, and pressure ulcer of the left buttocks.The 10/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. She was dependent on staff for toileting and transfers and required substantial to maximum assistance with showering, dressing, and bed mobility. It indicated the resident used a power wheelchair for mobility and required supervision during showers.B. Observation and resident interviewOn 10/13/25 at approximately 2:30 p.m. Resident #1 was observed sitting on a shower chair heading to the main shower room. She was being assisted by certified nurse aide (CNA) #2. CNA #2 pushed the shower chair along the hallway into the shower room and shut the door behind them.CNA #2 and Resident #1 were in the shower room for approximately 12 minutes.At 2:42 p.m., CNA #2 was observed leaving the shower room while Resident #1 remained alone in the shower room with the shower door closed.At 2:45 p.m., CNA #2 returned to the shower room with a couple of bath sheets.At 2:48 p.m., CNA #2 completed the shower and exited the shower room with resident #1 seated on the shower chair, covered with a bath sheet.At 2:50 p.m., Resident #1 arrived in her room with the assistance of CNA #2.At 2:52 p.m., CNA #2 left the resident's room for approximately two minutes and returned with CNA #1. Both CNAs entered the Resident's room and closed the door behind them.At 2:58 p.m., Resident #1 was observed lying in her bed.Resident #1 was interviewed on 10/14/25 at 10:34 a.m. Resident #1 said staff often left her alone in the shower room with the door closed to go and get shower items when they forgot to bring them into the shower . The resident confirmed she had been left alone in the shower room the previous day (10/13/25). She said the shower room call light was out of her reach and that scared her because she would be unable to call for assistance when she needed help when the CNA was gone and the bathroom door was closed. Resident #1 said she had a history of falls, and so it made her uncomfortable and afraid when she was left alone in the shower room with the door closed.C. Record reviewThe fall risk care plan, initiated 7/18/23 and revised 10/2/25, documented Resident #1 was at risk for falls due to paralysis, paraplegia, neuralgia, polyneuropathy, and thoracic vertebrae injury at the level of 11 and 12 (T-11 to T12) and use of high risk medications. Interventions included anticipating and meeting the resident's needs, ensuring the call light was within the resident's reach, and encouraging the resident to use her call light for assistance.-Despite the resident's fall risk, observation and resident interview revealed the resident was left unsupervised in the shower room for extended periods of time (see observations above).-However, per Resident #1, she was left unsupervised in the shower room for extended periods of time with the call light out of the resident's reach (see interview above).II. Staff interviewsCNA #1 was interviewed on 10/13/25 at 2:55 p.m. CNA #1 said all dependent residents could not be left alone unsupervised during showers. CNA #1 said Resident #1 had a diagnosis of paraplegia and was unable to walk. CNA #1 said the resident had a history of falls and should not be left unsupervised during showers. CNA #1 said all shower supplies should be gathered and readily available before starting a shower. CNA #1 said leaving a dependent resident unattended in the shower room could result in a fall, causing serious injuries.CNA #2 was interviewed on 10/13/25 at 3:00 p.m. CNA #2 said she was familiar with Resident #1 and had been educated to provide showers for dependent residents. CNA #2 said she left the shower room when Resident #1 had requested a bath sheet. CNA #2 said Resident #1 was a fall risk, but she was not aware that the resident could not be left alone in the shower room. CNA #2 said she did not place the call light within the resident's reach because she was going to be right back. CNA #2 said she could have used the call for assistance for another staff member to pick up the bath sheet. She said the resident could have fallen while she was in the shower room unsupervised. The assistant director of nursing (ADON) and the regional clinical resource were interviewed on 10/13/25 at 4:20 p.m. The ADON said Resident #1 was dependent on staff for showers and should not be left unsupervised during showers. The regional clinical resource determined that, due to Resident #1's intact cognitive level, she could be left