STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Post Acute Rehabilitation	4450 E Jewell 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to designate a registered nurse (RN) to serve as the director of nursing (DON) on a full-time basis.Specifically, the facility did not designate an RN to serve as the DON on a full-time basis after the DON's RN license expired on [DATE]. Findings include:Record review, observations and interviews confirmed the facility corrected the deficient practice related to the facility's failure to designate a registered nurse (RN) to serve as the director of nursing on a fall time basis prior to the onsite investigation on [DATE] to [DATE]. The deficiency was cited as past non-compliance with a correction date of [DATE].I. Record reviewReview of the DON's RN license history revealed the license expired on [DATE].II. Staff interviewsThe nursing home administrator (NHA) and the regional clinical resource were interviewed together on [DATE] at 11:15 a.m. The NHA said the facility was notified on [DATE] by the facility's service center (staff external to the facility) that the DON's RN license on file was expired. The NHA said the DON attempted to renew the nursing license online and in person the following day ([DATE]) but was unable to. The NHA said the facility designed a facility RN charge nurse as the DON on [DATE]. The NHA said the facility created a plan of correction to address the issue. The NHA said the DON's license renewal date was monitored by the facility's service center and not the facility staff and the DON did not get a reminder email to renew her license.III. Plan of correctionThe NHA provided the facility's plan of correction on [DATE]. The plan of correction documented the following:Immediate action to correct the deficient practice:On [DATE] the facility was notified the DON's RN license had expired.On [DATE] the facility designated an RN charge nurse as the interim DON.Identification of other residentsOn [DATE] the facility began an audit to review work completed by the DON after [DATE] that included resident assessments and orders to identify residents who were or could have been affected; the schedule was reviewed for RN coverage; and, the regional clinical resource and the medical director reviewed the assessments and orders and found no concerns.Systematic changes The facility's human resources director will monitor the license renewal dates of facility licensed and certified staff including the DON's license. An annual reminder for RN license renewal was added to the facility's online training.MonitoringThe facility's human resources director will verify all licensed and certified facility employees have active licenses with [NAME] monthly. An annual reminder for RN license renewal was added to the facility's online training.IV. Facility follow upThe NHA provided the DON's updated RN license on [DATE] at 11:43 a.m. with an effective date of [DATE] (after the survey).

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
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for one of three shower rooms, 12 of 22 sample resident room sinks and one (#2) of four residents reviewed for accident hazards out of 52 sample residents.Specifically, the facility failed to:-Ensure the water in facility shower rooms had safe bathing temperatures and staff had adequate monitoring equipment; and,-Ensure certified nurse aide (CNA) #5 transferred Resident #2 appropriately, which resulted in a fall for the resident. Findings include: I. Water temperature failures A. Facility policy and procedure The Water Temperatures policy and procedure, revised [DATE], was received from the nursing home administrator (NHA) on [DATE] at 6:35 p.m. It read in pertinent part, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit (F). Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. If at any time water temperatures feel excessive to the touch, staff will report this finding to their immediate supervisor. 2. Observations Water temperatures from random resident rooms and common areas were checked on [DATE] and found the following: At 10:05 a.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 133 degrees F. At 12:46 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 118.6 degrees F. At 12:54 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 125.2 degrees F. At 1:03 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 122.5 degrees F. At 1:20 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured again and found to be 126.9 degrees F. At 1:23 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be 122.4 degrees F. At 1:33 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 126.7 degrees F. At 1:37 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 121.1 degrees F. At 1:43 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 124.7 degrees F. 3. Facility's water temperature monitoring and documentation The facility's water temperature check log was provided by the NHA on [DATE]. The logs documented weekly monitoring of water temperatures in the three facility showers, three resident rooms, the kitchen and the laundry rooms. The log revealed the following: Water temperatures were measured on each floor of the building once per week from [DATE] through [DATE]. The facility water temperature in one of the resident rooms or shower rooms was measured to be below 100 degrees in three of the 11 instances recorded during this period. On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 114.5, 113.6 and 114.3 degrees F respectively. On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 115.3, 115.2 and 114.5 degrees F respectively. On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 116.5, 115.7 and 116.2 degrees F respectively. On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 116.5, 116.2 and 115.8 degrees F respectively. 4. Maintenance director interview and observations The maintenance director (MTD) was interviewed on [DATE] at 2:35 p.m. The MTD said the temperatures in his water maintenance logs typically ranged from 114 to 117 degrees F. The MTD said he checked each floor's water temperatures by measuring the temperatures in the shower rooms and one to two resident rooms per floor each week. The MTD said he also checked the water temperatures as needed if anyone reported any concerns. The MTD said he assessed the water temperature by letting the showers run for five minutes, and checked the temperature at first and after the five-minute mark. The MTD said he wanted the water temperatures to stay below the 120 degree F safe bathing threshold. The MTD said he checked the shower and room water temperatures with the same temperature probe each week. The MTD said the facility had recently had maintenance performed on its boiler due to issues with the facility's heat registers, but was not sure when the work was conducted. The MTD director was observed collecting the following water temperature measurements: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:43 p.m. the temperature of the shower room on the 400s hallway was measured at 116.6 degrees F. At 2:47 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 118.4 degrees F. At 2:49 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 126.8 degrees F. The MTD said the water was running hot and said he would address the issue right away. At 2:54 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 123.8 degrees F. The MTD said the temperature of the water in the sink had jumped up really fast. At 3:02 p.m. the hot water temperature for the 300s floor shower room was measured at 116.6 degrees F. At 3:03 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 122 degrees F. At 3:09 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 123.8 degrees F. At 3:12 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 114.8 degrees F. At 3:02 p.m. the hot water temperature for the 200s floor shower room was measured at 113 degrees F. At 3:20 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 120.2 degrees F. At 3:24 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 114.8 degrees F. At 3:27 p.m. the hot water temperature in room [ROOM NUMBER] was measured at 114.8 degrees F. 5. Staff interviews Certified nurse aide (CNA) #1 interviewed on [DATE] at 1:52 pm. CNA #1 said when assisting residents with bathing, he first tested the water temperature on his hand before the resident came into contact with the water. CNA #1 said he would then adjust the water and ask the resident if they felt comfortable with the temperature before proceeding. CNA #1 said if he could not adjust the temperature until it was comfortable, he would bathe the resident with wet wipes. CNA #1 said he would inform his supervisor and the maintenance staff immediately if there were any issues with the water temperatures. CNA #1 said he thought the maintenance staff checked the water temperature daily with a thermometer. CNA #2 was interviewed on [DATE] at 1:57 p.m. CNA #2 said when she was assisting residents with bathing, she checked the water temperature herself first and asked the resident to see if they were comfortable and if they were alert prior to bathing them. CNA #2 said if the resident was not alert or able to communicate, she would go slowly and relied on the resident's facial expressions and body language to determine if she needed to adjust the water temperature. CNA #2 said if she could not adjust the water to a comfortable temperature she would stop the shower and explain to the resident that they may need to perform a bed bath, then call maintenance and put in a work order to fix the bathing temperature issue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #3 was interviewed on [DATE] at 2:50 p.m. CNA #3 said when assisting residents with bathing, she first checked the water temperature with the back of her hand, and asked the resident to touch the temperature to see if they were comfortable. CNA #3 said she sometimes checked the water temperature prior to bathing if a thermometer was available in the shower room. CNA #3 said she thought the maintenance staff checked the temperature in the shower rooms every once in a while. CNA #3 said she had not heard any concerns from residents regarding the bathing temperature being too hot or too cold. The NHA was interviewed on [DATE] at 3:45 p.m. The NHA said the MTD checked water temperatures weekly and the water temperatures he had measured were all below 120 degrees F. The NHA said she had received a grievance regarding cold showers, so she had also been checking the water temperatures in the shower rooms. The NHA said in that instance, the cold shower issue had not been that the water was too cold, but that the hot water was not staying consistent throughout the resident's showers. The NHA said she had a company come out to fix the issue shortly thereafter, and it had turned out to be an issue with the facility's water pump. The NHA said they had currently had some construction occurring in the same area as the facility's water pump and wondered if the construction workers may have bumped into or hit the water mixer and accidentally adjusted it. The NHA said the facility staff were going around to check the residents' water temperatures every fifteen minutes since the water temperature issues were identified and the water temperatures observed on [DATE] were out of their normal range. The NHA said she had never seen the water temperatures so high. The NHA said the facility staff were also interviewing any residents who had showers on [DATE] about their water temperatures. The NHA said if they had found higher water temperatures during their weekly audits it would have come up in the quality assurance process, but it had not been an issue in the quality assurance meetings she had been a part of. The NHA said she would not want anyone to burn themselves in the shower, and said the residents in the facility had not had any burns or skin issues related to hot water. The NHA said she did not think it was sufficient to check just one room on each floor, so going forward the MTD would check the water temperature for two rooms on each floor along with the shower rooms. The NHA said the nurses had an emergency kit with a thermometer in it but did not always have a thermometer available in the shower room to test the residents' bathing temperatures. The NHA said the CNAs always tested the water on their own hands and would have the resident test the water temperature to ensure it was comfortable for them prior to bathing. II. Fall management failures A. Facility policy and procedure The Fall Management System policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 6:35 p.m. It read in pertinent part, It is the policy of this facility to provide an environment that remains free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #2 1. Resident status Resident #2, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included cauda equina syndrome (dysfunction of the collection of nerves at the end of the spinal cord), right sided hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke), colostomy and malignant neoplasm (cancer) of the bladder. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on nursing staff for toileting, chair-to-bed transfers and she turned side to side in bed with staff assistance. 2. Record review A review of Resident #2's electronic medical record (EMR) revealed the resident sustained a witnessed fall in her room on [DATE] at approximately 10:00 a.m. The [DATE] incident report, provided by the director of nursing (DON) on [DATE] at 5:59 p.m., revealed a CNA reported during the morning transfer the resident's legs gave out and the resident began to slide down the edge of the bed. The CNA lowered Resident #2 down to the ground. According to the incident report, the physician, nurse manager and family were notified, and Resident #2 did not sustain injuries from the fall. -However, the incident report failed to indicate which CNA was involved in Resident #2's fall. Further review of Resident #2's EMR revealed the CNA who worked with the resident on [DATE] was CNA #5. Resident #2's comprehensive care plan, initiated on [DATE] and revised on [DATE], revealed the resident was at risk for falls and has had an actual fall related to impaired mobility, weakness, pain, cauda equina syndrome, asthma, history of cerebrovascular accident (CVA; stroke), sciatica (compression of the sciatic nerve), fibromyalgia (chronic pain disorder) and apraxia (difficulty producing speech). A pertinent intervention, initiated on [DATE], included staff education on the use of the gait belt for transfers and two-person assist due to the resident's severe weakness from cauda equina syndrome. Resident #2's EMR revealed the resident's fall risk assessment score on admission was low, with a score of five. After Resident #2 sustained the fall on [DATE], the fall risk assessment was repeated and determined an at risk score of 10. The [DATE] fall interdisciplinary team (IDT) progress note documented a new intervention to be implemented of two-person assistance for transfer with staff. -However, according to the fall care plan, the intervention for Resident #2 to become a two-person assist for transfers with staff was initiated on [DATE]. C. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #5 was interviewed on [DATE] at 2:33 p.m. CNA #5 said she was involved in Resident #2's assisted fall. She said she prepared to transfer Resident #2 from the bed to the wheelchair. She said the resident looked wobbly and weak, so she attempted to sit Resident #2 on the bed. CNA #5 said the resident was seated on the edge and had to be assisted to the ground. CNA #5 said Resident #2 was wearing non-slip socks and a gait belt when she attempted to independently transfer the resident from the bed to her chair. She said Resident #2 usually required one-person staff assistance to transfer. The DON was interviewed on [DATE] at 2:46 p.m. The DON said when a fall was sustained by a resident, the staff should try to determine the root cause of the fall with an IDT approach. She said the initial response should include making sure the resident was safe and could access their call light. The DON said the care plan should be updated when new interventions. She said after Resident #2's fall on [DATE] the fall care plan was revised with new interventions, including the two-person assist with transfers. The DON said she was unable to determine if a two-person transfer occurred at the time of the fall. The DON was interviewed again on [DATE] at 4:13 p.m. The DON said CNA #5 transferred Resident #2 independently on [DATE]. She said CNA #5 did not know Resident #2 became a two-person assist with transfers. She said the new intervention that was implemented after Resident #2's fall on [DATE] of the resident becoming a two person transfer was not transcribed onto the CNA tasks, which led to CNA #5's lack of knowledge of the resident's current transfer status.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of four medication carts and one of two medication storage rooms.Specifically, the facility failed to ensure residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. Facility policy and procedureThe Medication Access and Storage policy, revised October 2025, was provided by the nursing home administrator (NHA) on 2/2/26 at 6:35 p.m. It read in pertinent part, It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications.II. ObservationsOn 1/29/26 at 11:53 a.m. medication cart #1 on the fourth floor was observed with licensed practical nurse (LPN) #3. The following item was found:-There was one fluticasone propionate 50 micrograms (mcg) per actuation (mcg/act) nasal spray bottle stored in an appropriately labeled medication box; however, the individual medication bottle inside was not labelled with the resident's name or the date the medication was opened for Resident #47.On 1/29/26 at 12:17 p.m. the third floor medication room was observed with LPN #4. The following items were found:-There was one 2 milligram (mg) per 3 milliliter (ml) subcutaneous Ozempic injector stored in an appropriately labeled medication box; however, the individual medication pen-injector inside was not labelled with the resident's name or the date the medication was opened for Resident #92.-There was one 4 mg per 3 ml subcutaneous Ozempic injector stored in an appropriately labeled medication box; however, the individual medication pen-injector inside was not labelled with the resident's name or the date the medication was opened for Resident #35.On 1/29/26 at 12:28 p.m. medication cart #2 on the third floor was observed with LPN #4. The following item was found:-There was one LubriFresh P.M. ophthalmic ointment stored in an appropriately labeled medication box; however, the individual medication tube inside was not labelled with the resident's name or the date the medication was opened for Resident #95.III. Staff interviewsThe assistant director of nursing (ADON) was interviewed on 1/29/26 at 11:53 a.m. The ADON said she understood that medication bottles should be labelled inside their respective medication boxes. She said the medication inside the box should be labelled because if the box were to get damaged, the nursing staff would know who the medication was intended for.LPN #4 was interviewed on 1/29/26 at 12:28 p.m. LPN #4 said the medication bottles should be labelled inside their respective medication boxes to prevent confusion if the medication boxes were to be destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.Specifically, the facility failed to:-Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfectingresident rooms and high-frequency touched areas (call lights, door handles and handrails); and,-Ensure urinary catheter tubing and collection bag were handled in a sanitary manner for Resident #100. Findings include:I. Housekeeping failuresA. Professional referenceAssadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 2/2/26 from https.//pubmed.ncbi.nlm.nih.gov. It read in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (viruses or microorganisms that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAI increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act a reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures,(revised 3/19/24) was retrieved on 2/2/26 from https://www.cdc.gov/healthcare-associatedinfections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=h It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedsidetables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, controlpanels), call bells and door knobs.Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.B. Facility policy and procedureThe Routine Cleaning and Disinfection policy and procedure, revised November 2025, was received from the nursing home administrator (NHA) on 2/2/26 at 6:35 p.m. It read in pertinent part, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Consistent surface cleaning will be conducted with a detailed focus on high touch areas to include, but not limited to, toilet flush handles, tray tables, call buttons, television remote, telephones, toilet seats, sinks and faucets, light switches, and door knobs.C. ObservationsDuring a continuous observation on 1/28/26, from 10:20 a.m. to 10:50 a.m., housekeeper (HK) #1 was observed cleaning rooms #315 and #310.HK #1 donned (put on) a new set of gloves, entered room [ROOM NUMBER] and began spraying Profect HP disinfectant into the sink in the common area between side A and side B of the room and on the raised toilet seat with handles. HK #1 removed the trash bags from the trash cans on both sides of the room and replaced them with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new bags. HK #1 returned to his cart, removed his gloves and donned new gloves without performing hand hygiene in between. HK #1 grabbed two microfiber rags from a bucket containing a disinfectant solution, placed one on the sink in the common area, and used the other to begin wiping the bedside table of side A. HK #1 wiped the bedside table surface down to the legs of the table. -HK #1 did not disinfect high-touch areas such as the residents' call light or remotes for the residents residing on either side of the room.HK #1 returned to his cart, removed his gloves and donned new gloves without performing hand hygiene. HK #1 began using the microfiber rag on the sink to begin wiping the top of the sink, then the inside of the sink basin, then along the countertop. HK #1 returned to his cart, removed his gloves and donned new gloves without performing hand hygiene. HK #1 grabbed another microfiber rag from the disinfectant bucket and placed it on the toilet seat. HK #1 grabbed a toilet brush from inside a bathtub in the room and used it to scrub the toilet bowl before setting it back down into the bathtub. -HK #1 did not disinfect the toilet brush after use. HK #1 did not return the toilet brush to an appropriate vessel to prevent further cross-contamination.HK #1 used the microfiber rag to wipe the toilet seat, then used another rag to wipe the inner rim of the toilet, then the toilet seat, then the toilet lid and flusher handle. HK #1 then disposed of the microfiber rags, removed his gloves and donned new gloves without performing hand hygiene. HK #1 placed a dry mop head onto the mop on side A, pushed the mop to side B, then swept the entire room moving from side B to side A before sweeping the debris into the room's doorway. HK #1 removed the dry mop head, swept up and disposed of the debris, and removed the dry mop head. HK #1 took a wet mop head out of a bucket containing a disinfectant solution , placed the mop head onto the floor in side A and pushed it into the bathroom to begin mopping the bathroom. HK #1 then removed the mop head and disposed of it, grabbed another mop head from the disinfectant solution bucket and began mopping side A. HK #1 removed the mop head and disposed of it, grabbed another mop head from the disinfectant bucket and placed it on the floor of side A before pushing it to side B. HK #1 then mopped the entirety of side B, mopped back through parts of side A, mopped part of the floor in side B, then mopped up through side A to the doorway of the room. HK #1 removed the mop head and disposed of it before replacing the dry mop head onto the mop. HK #1 used the dry mop head to dry the floors in side B then side A. HK #1 removed the dry mop head, removed his gloves and performed hand hygiene.-HK #1 failed to mop the two sides of the room separately.At 10:38 a.m. HK #1 donned new gloves, entered room [ROOM NUMBER] and spoke with the residents residing in the room. HK #1 grabbed a spray bottle of Profect HP disinfectant and sprayed the sink and toilet seat with the cleaner. HK #1 collected the trash on Side B of the room and discarded it, disposed of his gloves, performed hand hygiene and donned a new pair of gloves. HK #1 grabbed two microfiber rags from the disinfectant bucket and used one of the rags to clean the inside of the sink, then the top of the sink and the countertop. HK #1 then used the other microfiber rag to clean the toilet seat, then the underside of the seat, then the inner rim of the toilet. HK #1 grabbed a toilet brush kept beside the toilet in the bathroom, scrubbed the inside of the toilet bowl, and returned the toilet brush back to the container. -HK #1 did not disinfect the toilet brush after use.HK #1 returned to his cart, removed his gloves and donned a new set of gloves without performing hand hygiene. HK #1 placed a dry mop head onto the mop and began sweeping side B then side A. HK #1 removed the dry mop head, grabbed a broom and swept the debris from the floor into a dustpan and disposed of it. HK #1 removed his gloves, performed hand hygiene and donned new gloves. HK #1 grabbed a mop head from the disinfectant bucket, placed it on the floor in side A and pushed it into the bathroom to begin mopping the bathroom. HK #1 removed the mop head, grabbed a new mop head and placed it on the floor in side A, then pushed it to side B and began mopping side B. HK #1 finished mopping side B, and with the same mop head continued mopping side A. HK #1 removed the mop head, grabbed a new mop head, placed it on the floor on side A and pushed into side B, then mopped from side B to side A. -HK #1 failed to mop the two sides of the room separately.D. Staff interviewsThe housekeeping supervisor was interviewed on 1/29/26 at 2:00 p.m. The housekeeping supervisor said the housekeeping staff began cleaning rooms first by knocking and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Post Acute Rehabilitation	4450 E Jewell Ave Denver, CO 80222

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	waiting a few minutes before letting the resident know housekeeping was there to clean their room. The resident would reply and tell the staff member if they could come in or not. The housekeeping supervisor said the housekeeper would then start cleaning the room by spraying disinfectant spray on the residents' call lights, sink, doorhandles, bed remotes, and on the bathroom surfaces. The housekeeping supervisor said the housekeeper would then retrieve rags from a bucket containing the same disinfectant solution, and use the rags to clean the tables and remote controls, the sink, and the toilet, with each surface getting its own color rag. The housekeeping supervisor said the disinfectant had to remain on the surface for two minutes. The housekeeping supervisor said the housekeeping staff should use one mop head for each separate side of the room, and one mop head to mop the bathroom.The housekeeping supervisor said the toilet was always cleaned last. The housekeeping supervisor said the housekeeping staff should clean the toilet starting from top to bottom, and should clean the seat of the toilet last. The housekeeping supervisor said the housekeeping staff should be folding the rag over as they were cleaning the toilet so a fresh side would be touching the surface. The housekeeping supervisor said the toilet brushes were kept in a container in the residents' bathroom. The housekeeping supervisor said the toilet brush should not be left in the resident's bathtub.The housekeeping supervisor said the housekeeping staff needed to sanitize their hands between each glove change.The infection preventionist (IP) was interviewed on 1/29/26 at 2:31 p.m. The IP said toilet brushes should be stored on the housekeeper's cart, and not stored in the resident's bathtub. The IP said the housekeeping staff should clean from cleanest to dirtiest, and work starting from the toilet handle and clean the toilet bowl last. The IP said the housekeeping staff should be cleaning high-touch areas including handrails, door handles, bed remotes, television remotes, side tables and call lights. The IP said the housekeeping staff should use separate mop heads for each side of the residents' rooms.II. Urinary catheter failuresA. ObservationsOn 1/26/26 at 10:35 a.m. Resident #100 was sitting in his wheelchair. His catheter collection bag was sitting on the floor in a privacy bag.At 3:21 p.m. Resident #100 was lying in his bed. His catheter bag was attached to his bed, and the urinary catheter tubing was touching the ground.On 1/27/26 at 8:20 a.m. Resident #100 was lying in bed with his bed in the lowest position. Resident #100's catheter bag was attached to his bed, and the catheter bag was resting folded over on the floor.At 5:18 p.m. Resident #100 was lying in bed. His catheter bag was clipped to the foot of his bed, and the bag was resting on the floor.On 1/28/26 at 10:14 a.m. Resident #100 was sitting on the side of his bed with his catheter bag clipped to his bed and the bed in lowest position. Resident #100's catheter bag was slipping out of the bottom of the privacy bag with the bottom of the catheter bag folded over and resting on the floor. Resident #100's catheter tubing between the bag and the resident's leg was resting on the floor.At 11:02 a.m. HK #1 was mopping Resident #100's room. HK #1 donned gloves, put a mop head onto Resident #100's side of the room, pushed the mop through the room into the bathroom and began mopping the bathroom. HK #1 removed the mop head, grabbed a new mop head and began mopping Resident #100's side of the room. With the same gloved hands, HK #1 grabbed Resident #100's catheter tubing and lifted it off the floor, mopped underneath the area, and placed the tubing back onto the floor to continue mopping.On 1/29/26 at 12:19 p.m. Resident #100 was lying in bed. Resident #100's catheter bag was clipped to his trash can, with the bottom of the catheter bag folded over and touching the floor.At 1:08 p.m. Resident #100 was sitting up in bed eating his lunch. Resident #100's catheter bag was clipped to the trash can, and his catheter bag and tubing were touching the floor.B. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on 1/29/26 at 12:53 p.m. LPN #4 said the nursing staff provided catheter care each shift, and changed the catheter bags once per week. LPN #4 said the staff needed to wear a gown and gloves when handing the urinary catheter. LPN #4 said it was not okay for the urinary catheter tubing or bag to touch the floor, and the resident should have a basin to put the urinary catheter bag into, or clip the bag to their wheelchair or bed. LPN #4 said the catheter bag and tubing could not touch the floor as it was an infection control risk due to the catheter being a line that went into their body, and said the staff wanted to prevent infections as much as possible. (continued on next page)

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	065230	A. Building B. Wing	01/29/2026

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	065230	A. Building B. Wing	01/29/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#118) of 10 residents out of 52 sample residents. Specifically, the facility failed to ensure an assessment was conducted to determine whether the self-administration of medications was clinically appropriate for Resident #118. Findings include:I. Resident #118A. Resident statusResident #118, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included third degree burn to the lower legs bilaterally (both legs) and anxiety disorder.The 1/27/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.B. Resident observation and interviewOn 1/29/26 at 8:17 a.m. registered nurse (RN) #2 prepared to administer medications to Resident #118, including Brimonidine tartrate ophthalmic solution (a medication used to treat glaucoma) 0.2 % eye drops.Resident #118 said he was an adult and he could administer the eye drop to his left eye independently.Resident #118 self-administered the Brimonidine eye drops with RN #2's supervision.Resident #118 self-administered two drops of the Brimonidine eye drops to the left eye independently.C. Record reviewReview of Resident #118's January 2026 CPO revealed the following physician's order:Brimonidine tartrate ophthalmic solution 0.2%, one drop to the left eye twice a day for ocular hypertension.-Review of Resident #118's electronic medical record (EMR) did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #118 was able to safely administer his own medications.Cross referenced F759: failure to ensure the medication error rate was less than 5%.D. Staff interviewRN #2 and the assistant director of nursing (ADON) were interviewed together on 1/29/26 at 12:11 p.m. RN #2 said she was not sure if Resident #118 had a self-administration assessment completed and began to look in the resident's EMR to see if it had been completed.The ADON said Resident #118 did not have a completed self-administration assessment, and only three to four residents in the whole building had a completed assessment. After searching in the resident's EMR, RN #2 agreed the assessment had not been completed. RN #2 said Resident #118 was non-compliant, often refused care and she had heard that if the resident did not like the way she did things then he might become aggressive.The ADON was interviewed again on 1/29/26 at 1:30 p.m. The ADON said she completed a self-administration assessment for Resident #118, contacted the provider to get the resident's eye drop orders to include the resident was able to independently administer medication under supervision and created a progress note which read in pertinent part, the resident was able to independently administer all eye drops under supervision, in accordance with provider instructions. She provided documentation of the changes made to the resident's EMR at that time.-However, the self-administration assessment was not completed until 1/29/26 (during the survey).

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	065230	A. Building B. Wing	01/29/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for two (#9 and #113) of seven residents reviewed for behavioral and emotional status out of 52 sample residents.Specifically, the facility failed to:-Identify and implement person-centered interventions after an assessed decline in mood and history of trauma for Resident #9; and,-Coordinate timely necessary behavioral, mental and emotional health care and services for Resident #113 after the resident expressed suicidal ideation. Findings include:I. Facility policy and procedureThe Behavioral Health Services policy and procedure, revised October 2025, was received from the nursing home administrator (NHA) on 2/2/26 at 6:35 p.m. It read in pertinent part, Trauma survivors will receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The Social Service designee will also meet with resident and/or resident representative and attempt to identify possible psychosocial issues and needs that may be causing the behaviors or having an impact on resident's function, mood, and cognition. The plan of care will include non-pharmacological interventions and individualized, person-centered care approaches as well as trauma-informed approaches in accordance with resident's customary routines, with input from the resident and/or resident representative. Residents whose assessment did not reveal a diagnosis of mental or psychosocial adjustment difficulty, history of trauma, or post-traumatic stress disorder (PTSD) will have a plan of care developed to prevent a pattern of decreased social interaction and/or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that development of such pattern was unavoidable.II. Resident #9A. Resident statusResident #9, age less than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes, alcohol use with unspecified alcohol-induced disorder, unsteadiness on feet and need for assistance with personal care.The 11/9/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15.The PHQ-9 (patient health questionnaire for depression) assessment documented the resident had poor appetite or overeating in two to six days over the 14 day look-back period for the assessment. The assessment documented the resident had little interest or pleasure in doing things nearly every day of the 14 day look-back period for the assessment. The resident had a score of four out of 30 on the assessment, which indicated minimal depression.B. Record reviewThe cognition care plan, revised 11/5/25, revealed Resident #9 was at risk for impaired cognitive function or impaired thought processes due to his diabetes diagnosis, alcohol abuse and pain. Pertinent interventions included monitoring and documenting any changes in cognitive function and social services providing psychosocial support as needed.The language care plan, revised 11/5/25, revealed Resident #9 was at risk for a communication problem due to a language barrier as the resident spoke only Arabic. Pertinent interventions included providing a translator as necessary, using a translation tablet to communicate with the resident, and monitoring and recording any decline in cognitive status or mood.The psychosocial care plan, revised 11/14/25, revealed Resident #9 was at risk for psychosocial wellbeing problems due to his history of alcohol abuse and admission to the facility. Pertinent interventions included assisting, encouraging and supporting Resident #9 with setting realistic goals, allowing the resident time to answer questions and to verbalize his perceptions and fears, and removing the resident when conflict arose to a calm safe environment.The mood problem care plan, revised 11/5/25, revealed Resident #9 was at risk for a mood problem due to his history of alcohol abuse. Pertinent interventions included encouraging Resident #9 to express his feelings, (continued on next page)

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	065230	A. Building B. Wing	01/29/2026

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South Valley Post Acute Rehabilitation	4450 E Jewell Ave Denver, CO 80222

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring and recording any mood patterns including signs/symptoms of depression, anxiety or sad mood, and monitoring and reporting to the physician any acute episodes of loss of pleasure or interest in activities, changes in appetite, and feelings of worthlessness or guilt.-Review of Resident #9's comprehensive care plan did not reveal any documentation of the resident's trauma history, nor any person-centered interventions related to his mood or behavior.A physician note, dated 11/3/25 at 3:00 p.m., revealed Resident #9 was to continue outpatient psychiatric therapy for his alcohol use disorder and depression. Resident #9 had a significant increase in alcohol use from February 2025 due to grief from the murder of his family in [NAME], and he was unable to mourn or process his grief effectively. Resident #9 had a history of refusal of psych meds and services, and the physician's plan included monitoring of the resident's mood and behavior and offering behavioral health services as needed.The 11/5/25 PHQ-9 documented the resident had poor appetite or overeating in two to six days, had little interest or pleasure in doing things nearly every day of the 14 day assessment period.The assessment documented the resident had minimal depression with a score of four out of 30.The 11/5/25 social services admission assessment documented Resident #9 did not have any psychosocial needs and did not have any history of trauma. The assessment documented the resident requested a translator when speaking with his physician as he primarily spoke Arabic. The assessment documented Resident #9 had mild cognitive impairment and had minimal depression.-However, according to the physician progress notes dated 11/3/25, the resident had a history of trauma related to the murder of his family in [NAME] and had significant alcohol use due to his grief.The 12/10/25 PHQ-9 revealed the resident had little interest or pleasure in doing things increased to nearly every day, felt tired or had little energy for half or more of the days, felt bad about himself nearly every day and felt he was moving or speaking slowly or was restless/fidgety on half or more days during the 14 day assessment period.Resident #9's depression score increased to 10 out of 30, which indicated he had moderate depression.A social services assessment, dated 12/12/25, revealed Resident #9 was reviewed by the social services team for his quarterly evaluation. The assessment documented Resident #9 did not have any psychosocial needs and did not have any history of trauma. The assessment documented the resident did not request a translator when speaking with his physician. The assessment documented Resident #9 was cognitively intact and had moderate depression.-However, Resident #9 had an increase in his assessed depression from mild to moderate and had a documented history of trauma. The resident's medical record did not reveal documentation that the facility had intervened when the resident's depression had worsened.C. Staff interviewsThe social services director (SSD) and social services assistant (SSA) were interviewed together on 1/29/26 at 10:07 a.m. The SSD said mood assessments were conducted when the resident was admitted , quarterly, if the resident had any change in condition or reported they were having a rough day, and at discharge. The SSD said they offered behavioral health services to residents when first admitted and documented whether the resident declined them. The SSD said if a resident's PHQ-9 depression assessment score declined, the social services staff would offer behavioral health services and psychosocial support to the residents, contact family for support and document the resident's response in the social services assessment.The SSA said Resident #9 did not leave his room very often. The SSA said Resident #9 was fairly neutral in mood, and was very nice and welcoming whenever she went into his room. The SSA said she had not seen any tearfulness or sadness from Resident #9 and said the resident had not complained to the social services team about anything. The SSA said Resident #9 did not have any history of trauma. The SSD said Resident #9 reported minimal depression during his initial assessment upon admission.The SSA said Resident #9 had moderate depression according to his mood assessment on 12/10/25. The SSA said she had not conducted the PHQ-9 with Resident #9 and was unsure what steps were taken when his score increased to indicate he went from mild to moderate depression on 12/10/25.Both the SSA and SSD said the residents' mood and behavior care plans had person-centered non-pharmacological interventions.The SSA said Resident #9's care plan included interventions such as encouraging the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident to express his feelings and to monitor and record his mood. The SSA said taking walks helped Resident #9 feel better, but otherwise the resident kept to himself and did not like to do much besides going on walks and being in his room.-However, Resident #9's care plan did not document any person-centered interventions related to his mood and behavior (see record review above). Certified nurse aide with medication authority (CNA-Med) #1 was interviewed on 1/29/26 at 10:59 a.m. CNA-Med #1 said Resident #9 stayed in his room most of the time, was a nice person but felt alone. CNA-Med #1 said she tried to get offer snacks and encouraged him to get out of his bed and talk to people. The director of nursing (DON) and assistant director of nursing (ADON) were interviewed together on 1/29/26 at 4:15 p.m. The DON said Resident #9 spoke a little bit of English but primarily spoke Arabic. She said a translation application on a tablet was used to communicate with Resident #9.The ADON said Resident #9 was not happy with being at the facility when he was first admitted , but became okay with being there over time. The ADON said they had to move the resident to the long-term care floor of the facility, which made Resident #9 a little sad. The ADON said she was not aware of any history of trauma for Resident #9. The DON said Resident #9 had a history of alcohol abuse and had a care plan for a mood problem related to his alcohol abuse. The ADON confirmed the physician's progress note discussed Resident #9's grief from the murder of his family in [NAME] and that he was unable to express his grief. The DON confirmed the information regarding the resident's trauma and grief was not included in the resident's comprehensive care plan. The DON said for residents with histories of trauma behavioral health services should be offered. The DON said she would create a trauma-informed care plan for Resident #9. The DON said if a resident was having mood issues the staff could also put the resident on behavior tracking even if they were not on any behavioral medications.III. Resident #113A. Resident statusResident #113, age greater than 68, was admitted on [DATE] and passed away on 11/9/25. According to the November 2025 CPO, diagnoses included speech and language deficits following cerebral infarction (stroke), muscle wasting, malignant neoplasm (cancer) of bone, and spinal stenosis (narrowing of spaces in the spine commonly causing pain, numbness, and weakness in the back, neck, legs, or arms).The 9/29/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15.The assessment indicated the resident had no behaviors. A PHQ-9 assessment was not conducted at the time.B. Record reviewThe cognitive function care plan, initiated 8/15/25, revealed Resident #113 was at risk for impaired cognitive function or impaired thought processes due to pain, medication side effects and history of stroke. Pertinent interventions included administering medications as ordered, monitoring and documenting any changes in cognitive function including memory and mental status, and social services providing psychosocial support as needed.The mood care plan, initiated 8/27/25, revealed Resident #113 had a potential for mood problems due to his admission to the facility and decline in his ability to perform tasks of daily living. Pertinent interventions included monitoring, documenting and reporting to the physician any mood patterns including signs or symptoms of depression, anxiety or sad mood and encouraging the resident to express his feelings.The depression care plan, initiated 8/19/25, revealed Resident #113 was at risk for depression due to a PHQ-9 score of 13 out of 30. Pertinent interventions included encouraging the resident to express his feelings and offering mental and behavioral health support as needed.The 8/18/25 PHQ-9 revealed Resident #113 had trouble falling or staying asleep, felt tired or had little energy and moved slowly or was fidgety/restless nearly every day and felt down, depressed or hopeless and felt bad about himself more than half of the days during the 14 day assessment period.The assessment documented the resident had a score of 13 out of 30, indicating moderate depression.The 9/30/25 quarterly PHQ-9 documented the resident's depression score increased to 14 out of 30.A social services assessment, dated 12/12/25, revealed Resident #113 was reviewed by the social services team for his quarterly evaluation. The assessment documented the resident did have psychosocial needs as he scored a 14 on his mood assessment, however the resident declined mental and behavioral health services.A progress note, dated 10/16/25 at 10:07 a.m., revealed Resident #113 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	01/29/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had weight loss likely resulting from his cancer progression. The registered dietician and physician's assistant met with the resident to discuss his overall health decline and his not wanting to go to his oncology follow-up appointment. Resident #113 elected to pursue comfort care at the time without further oncology intervention.A physician progress note, dated 10/16/25 at 11:01 a.m., revealed the physician was informed by the DON that Resident #113 was refusing and canceling his upcoming oncology appointment. Resident #113 was more accepting of his progressive decline in health and the severity of his condition. The resident was aware of his poor prognosis due to his recent significant loss in function to his spine and both lower extremities, and continued to request to stop pursuing cancer treatment. Resident #113 was agreeable to a comfort care focus. A progress note, dated 10/23/25 at 11:41 a.m., revealed Resident #113 was at a high risk for skin breakdown due to his mobility issues and diagnosis of advancing cancer. Resident #113 would be transitioning to long-term care as he could no longer manage his self care. Resident #113 was considering palliative care as he was not ready to make the decision for hospice at the time.A progress note, dated 11/3/25 at 9:55 a.m., revealed the day prior (11/2/25) Resident #113 reportedly verbalized his wishes to end his life. On 11/3/25 when the nursing staff talked with Resident #113 about his statement the day prior, the resident said he realized his right arm was useless and knew his left arm would be the same soon and he would not be able to move. Resident #113 said he could not live like that and wished to die. When asked how he would accomplish that, Resident #113 said he would just lay in his bed and not eat. Resident #113 said he was comfortable and not in pain and wanted to be left alone. Resident #113 was given his call light but said he soon would not be able to use it.A social services progress note, dated 11/3/25 at 10:13 a.m., revealed a social services staff member spoke with Resident #113 about his suicidal ideation concerns. The social services staff asked Resident #113 who or what was helpful when he was feeling upset, to which the resident said speaking to his sister and having visits from her was helpful.A progress note, dated 11/3/25 at 10:20 a.m., documented Resident #113 said he was going to commit suicide by refusing all of his medications and food. Resident #113 was placed on 15 minute safety checks.-However, it was not documented whether Resident #113's physician was notified at the time.A physician note, dated 11/3/25 at 3:00 p.m., revealed the physician saw Resident #113 for a hospice discussion. Resident #113 reported increased weakness, and acknowledged that without treatment he would likely get worse. Resident #113 reported he was comfortable discussing options with hospice. The note documented the DON would send a hospice referral. The physician's assessment documented the resident did not have any current depressed mood, anxiety or agitation. -The physician note did not document any discussion or review of Resident #113's mention of suicidal ideation on 11/2/25.A physician note, dated 11/5/25 at 2:42 p.m., revealed the physician saw Resident #113 to follow-up on the resident's muscle spasticity and pain management. Resident #113 said his spasms were well controlled and did not feel the need to increase his medication dosage. The note documented the resident did not have any further questions or concerns. The note documented Resident #113's mood was stable and without agitation.-The physician note did not document any discussion or review of Resident #113's mention of suicidal ideation on 11/2/25.Progress notes, dated 11/3/25 at 9:31 p.m. through 11/7/25 at 8:11 a.m. revealed Resident #113 had multiple instances of refusing all medications aside from his as-needed doses of oxycodone (an opioid pain medication).A progress note, dated 11/8/25 at 6:21 p.m., revealed Resident #113 had only eaten his breakfast meal. Resident #113 had refused his lunch and his dinner but had drunk fluids at both mealtimes.A progress note, dated 11/9/25 at 6:36 a.m., revealed Resident #113 was found with no pulse and no respirations at 6:30 a.m. that morning (11/9/25). Resident #113 had complained of pain/discomfort at 2:00 a.m. that morning and had been medicated for his pain. Resident #113 complained of back pain again at 5:00 a.m. that morning, and the nurse on duty repositioned him and said he could receive another dose of pain medication at 6:00 a.m.Review of Resident #113's electronic medical record (EMR) did not reveal any social service follow-up notes, lethality assessments (see interview below), or documentation that behavioral health services were offered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Post Acute Rehabilitation	4450 E Jewell Ave Denver, CO 80222

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following Resident #113's mention of suicidal ideation on 11/2/25.An email from a hospice caseworker, dated 1/28/26 at 6:13 p.m., revealed the hospice company was contacted by the facility's resident services resource on 11/3/25 for Resident #113. The email documented the hospice caseworker received a call from the resident services resource on 11/3/25, who said Resident #113 was having a health decline and stated he was ready to die. On 11/5/25 the hospice service visited the facility and the hospice caseworker and resident services resource spoke with Resident #113 to discuss end of life support. When the hospice caseworker asked Resident #113 about his statements about dying, he denied feeling that way. Resident #113 said he was no longer having a health decline and said he was feeling fine and did not want to die. Resident #113 said he would call the hospice caseworker when he felt like he needed hospice services.C. Staff interviewsThe SSD, SSA and social services resource were interviewed together on 1/28/26 at 4:36 p.m. The SSD said when residents expressed suicidal ideation, the social services department conducted a lethality assessment for the resident, documented it in their EMR, and informed the resident's family and their physician. The SSD said the social services team would create a safety plan with the resident, assess them for mental health triggers, and offer the resident behavioral health services if it was not already in place. The SSD said the triggers, safety plan and offer of behavioral health services were all documented in the lethality assessment.The SSA said Resident #113 initially admitted to the facility for skilled therapy, but had cancer and passed away quickly from his condition. The SSA said Resident #113 was sad because of his disease process and losing his mobility.The SSD and the social services resource said Resident #113 was offered behavioral health services when he first admitted and several times throughout his stay at the facility during each social services assessment.-However, his last documented social services assessment was on 9/30/25 (see record review above).The SSD said after Resident #113 expressed suicidal ideation on 11/3/25, the SSA had spoken to the resident and initiated 15 minute safety checks. The SSA said she did not conducted a lethality screening following Resident #113's suicidal ideation. The SSA said she had notified the interdisciplinary team, the nurses on duty that day and Resident #113's provider following his statement regarding suicidal ideation. The SSA said she had also contacted Resident #113's sister as that was his support person.-However, review of Resident #113's EMR did not reveal any documentation that his sister or physician were contacted regarding his statements of suicidal ideation.The resident services resource was interviewed on 1/29/25 at 9:57 a.m. The resident services resource said she was working in the social services department at the time when Resident #113 was in the facility. The resident services resource said Resident #113's physician was consulted on 11/3/25 after the resident expressed suicidal ideation. The resident services resource said the provider must have been notified, as that would be the only reason the physician would have visited Resident #113 so frequently.-However, the physician documented the reason for visiting Resident #113 on 11/3/25 was to discuss hospice, and the reason for visiting the resident on 11/5/25 was to follow up on the resident's muscle spasticity. The physician's visits did not document any suicidal ideation (see record review above).The resident services resource said she thought the SSA based her course of action based on how Resident #113 was presenting to her at the time, and did not feel like a lethality assessment was needed. The resident services resource said behavioral health resources were offered to Resident #113 on 11/3/25.-However, review of Resident #113's EMR did not reveal any documentation that behavioral health services were offered after the resident expressed suicidal ideation.The resident services resource said Resident #113's health was declining significantly, and he had been making comments indicating he wanted to pass away, but said she did not view it as suicidal ideation.

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	065230	A. Building B. Wing	01/29/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent (%).Specifically the facility's medication error rate was 7.69%, or two errors out of 26 opportunities for error. Findings include:I. Facility policy and procedureThe Medication Administration policy, revised October 2025, was provided by the nursing home administrator (NHA) on 2/2/26 at 6:35 p.m. It read in pertinent part, It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Medications may not be set up in advance and must be administered within one hour before or after their prescribed time. Should a drug be withheld, refused or given other than at the scheduled time it should be appropriately documented on the medication administration record (MAR).II. Resident #86A. ObservationOn 1/28/26 at 9:34 a.m. licensed practical nurse (LPN) #2 prepared to administer medications to Resident #86. LPN #2 dispensed the resident's medications into a medication cup, including a pantoprazole sodium (medication used to treat excess acid in the stomach) delayed release 40 milligram (mg) oral tablet.LPN #2 administered the medications to Resident #86, including the 40 mg pantoprazole sodium tablet.-LPN #2 administered the incorrect dose of pantoprazole sodium to Resident #86 (see physician's order below).B. Record reviewReview of Resident #86's January 2026 computerized physician orders (CPO) revealed the following physician's order:Protonix (pantoprazole sodium) tablet delayed release 20 mg every day for heartburn.C. Staff interviewLPN #2 was interviewed on 1/28/26 at 10:49 a.m. LPN #2 said she would look at the resident's orders in the MAR while dispensing medications to make sure she followed the five rights of medication administration: right name, right time, right dosage, right route and accurate documentation. She said it was important to compare the medication order to the medication she was dispensing because the orders changed frequently, and the nursing staff would not know if the dose had changed.LPN #2 said pantoprazole sodium was indicated for heartburn and she did not realize that she administered the incorrect dose to Resident #86. She said if a resident received the incorrect dose of a medication, the resident could have side effects. LPN #2 said once someone notified her of her mistake, or she became aware of a mistake, she would call the physician to notify them of the error and complete a change of condition form as appropriate.III. Resident #118A. ObservationOn 1/29/26 at 8:17 a.m. registered nurse (RN) #2 prepared to administer medications to Resident #118, including Brimonidine tartrate ophthalmic solution (a medication used to treat glaucoma) 0.2 % eye drops.Resident #118 self-administered the Brimonidine eye drops with RN #2's supervision.Resident #118 self-administered two drops of the Brimonidine eye drops to the left eye independently.-RN #2 failed to instruct the resident to administer one drop to the left eye prior to Resident #118's self-administration of the Brimonidine eye drops (see physician's orders below).B. Record reviewReview of Resident #118's January 2026 CPO revealed the following physician's order:Brimonidine tartrate ophthalmic solution 0.2%, one drop to the left eye twice a day for ocular hypertension.-Review of Resident #118's electronic medical record (EMR) revealed a self-administration assessment had not been completed at the time of the observation.Cross reference F554: failure to an assessment was completed prior to the self-administration of medications. C. Staff interviewsRN #2 and the assistant director of nursing (ADON) were interviewed together on 1/29/26 at 12:11 p.m. RN #2 said she thought Resident #118's Brimonidine order was for two drops in the left eye because the resident had two different eye drop medications on the MAR. After she looked at the MAR, RN #2 said she was incorrect and the Brimonidine order was for one eye drop in the left eye.