STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a comfortable and homelike environment in three of four units.Specifically, the facility failed to:-Ensure the blinds, window sills, wall air conditioners and walls in resident rooms were clean and in good repair; and,-Ensure facility spas were in good working condition and the tile was in good repair. Findings include: I. Facility policy and procedure The Homelike Environment Policy, revised February 2021, was provided by the nursing home administrator (NHA) on 6/25/26 at 7:55ˆa.m. It read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment; inviting colors and décor personalized furniture and room arrangements. The Cleaning and Disinfecting Residents' Rooms policy, revised February 2026, was provided by the NHA on 6/25/26 at 7:55ˆa.m. It read in pertinent part, Resident rooms are cleaned regularly and as needed by housekeeping/environmental services. If the resident is in their room, request permission to enter and clean the room. If the resident is sleeping, showering, dressing, using the toilet, eating, or has visitors, reschedule the cleaning. Do not interrupt the resident during these activities to clean the room. Check the blinds, curtains, and windows. Clean if necessary. Terminal room cleaning: Check the blinds, curtains, and windows. Clean if necessary. II. Ensure the blinds, window sills, wall air conditioners and walls in resident rooms were clean and in good repair A. Observations On 6/21/26 at 3:15 p.m. the blinds in resident room [ROOM NUMBER] were coated with visible dust and cob webs. There were dead bugs in the window sill. On 6/21/26 at 4:48 p.m. Resident room [ROOM NUMBER] was observed to have a layer of dust on the window sill. There was dust and small pieces of debris in the wall air conditioner. On 6/22/26 at approximately 10:30 a.m. resident room [ROOM NUMBER] was observed to have (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
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple brown spots of various sizes, from approximately one quarter of an inch to one inch on the wall behind the bed from the privacy curtain in the middle of the room to the far wall. On 6/22/26 at 2:20 p.m. resident room [ROOM NUMBER] was observed to have approximately one inch of wallpaper missing around the perimeter of the walls of the bathroom between the baseboard and the wall. The edge of the wallpaper was peeling around the entire bathroom where the missing strip of wallpaper was. On 6/22/26 at 2:30 p.m. there was a hole observed the bathroom door of resident room [ROOM NUMBER]. On 6/24/26 at 10:05 a.m. Resident #121's wheelchair was observed to have small particles of white and gray dust and debris on one side of her wheelchair. On 6/24/26 at 10:10 a.m. room [ROOM NUMBER] was observed to have a missing door bolt, latch and face plate. Part of the door around the door handle was broken off and missing and exposed the interior of the door. On 6/24/26 at 3:10 p.m. room [ROOM NUMBER] was observed to have cob webs in the windowsill. The window jambs (sides and edge of the window opening) on the top and sides had multiple small pinpoint black spots. Wallpaper had peeled off the top and side window jambs and was hanging off the jamb approximately 2-3 inches for the three sides of the window. There was dust and debris inside the wall air conditioner and on the knobs. The wallpaper near the door to the room separated from the wall at the seams approximately six inches in length. The edge of the wallpaper was peeling around the entire bathroom where the missing strip of wallpaper was. B. Resident interviews The resident in room [ROOM NUMBER] was interviewed on 6/21/26 at 3:15 p.m. Resident #121 said the blinds in her room did not block the sun and she put the curtains up (over the blinds) a year ago. The resident in room [ROOM NUMBER] was interviewed on 6/24/26 at 10:05 a.m. Resident #109 said the dust from the wall air conditioner blew on her wheelchair leaving dust and debris on her wheelchair. The resident in room [ROOM NUMBER] was interviewed on 6/21/26 5:05 p.m. Resident #142 said her door was broken and had gotten stuck in the closed position and the maintenance director had to use tools to open the door. The resident in room [ROOM NUMBER] was interviewed on 6/22/26 at 2:30 p.m. Resident #105 said the hole was in the door prior to her moving into the room. She said she did not know what caused the hole. Resident #105 said no facility staff member had offered to fix it. The resident in room [ROOM NUMBER] was interviewed on 6/24/26 at approximately 3:10 p.m. Resident #10 said to look at the window in his room. Resident #10 said the wallpaper was peeling off his window. He said the facility sprayed the black spots in the window with bleach but the black spots did not disappear. Resident #10 said he did not have a window screen for his window. C. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The housekeeping supervisor was interviewed on 6/25/26 at 2:13 p.m. The housekeeping supervisor said the staff had cleaned the bathroom walls in room [ROOM NUMBER], but the wallpaper was still brown and peeling from the bottom. She said the staff tried to clean the walls everyday but sometimes it was hard because the resident would be in the room and not let them clean. She said the resident in #305 would not let the staff clean the blinds because the resident had breathing problems. The housekeeping supervisor said that when staff did a deep clean, they cleaned the mattress, frame of the bed, privacy curtain, closet, walls, clean sheets, linens, pillow and cleaned the bathroom. She said the staff tried to clean the walls when a resident was discharged because it was very difficult to clean the walls while the resident was in the room. She said the air conditioning units were cleaned during the deep cleans and the staff dusted the unit and took the filters out and dust them. She said her staff deep cleaned everyday as best as they could if the resident let them. She said that her staff would tell her when they see something was broken or needs repaired and then she would let maintenance know. She said that window sills should be cleaned every day and privacy curtains should be cleaned on deep cleans. She said there was a list of rooms for each day that should be getting deep cleaned. She said she had permanent people scheduled for their permanent areas and those people have their certain duties. She said she would have her staff do their assigned duties first then she would walk their halls and point things out to them and have them clean those areas. She said that the shower rooms are cleaned everyday, sometimes more than once. She said that the certified nurse aides (CNAs) were responsible to clean after each resident. She said she was unsure of what the CNAs used to clean the showers. The NHA was interviewed on 6/25/26 at 4:06 p.m The NHA said they were remodeling the dry wall, FRP (fiberglass reinforced panels), blinds, lights, and were taking down wall paper in the facility. He said the door to room [ROOM NUMBER] was stuck and the maintenance director had to use something to open the door and it was going to be repaired and had been broken for approximately 10 days to two weeks. The NHA said room [ROOM NUMBER] had been sprayed in the window jamb. The NHA said when the facility turned rooms after a resident discharged they painted and cleaned the air conditioner, and there was no documentation of refusal to allow room cleaning. II. Failed to ensure facility spas were in good working condition A. Resident interview Resident #105 was interviewed on 6/22/26 at 2:30 p.m. Resident #105 said the shower head in the shower room was broken and wrapped with coban wrap (a lightweight, self-adhering wrap that is often used to secure dressings). She said she struggled to shower, because she used one hand to hold the shower head up and the other hand to support her nephrostomy site (a procedure to insert a thin catheter through the lower back directly into the kidney). B. Observations of shower rooms On 6/24/26 at 9:29 a.m. the following was observed: Outside of the Heritage [NAME] shower room, approximately one to two feet away from the door of the shower room, the ceiling tile was stained a yellow color and was drooping down. The paint on the wall beneath the ceiling tiles was bubbling and felt damp to the touch. The bubbled paint started from the ceiling and went halfway down the wall. The wall below where the paint was bubbled, dipped into where the floor meets the wall was visible. The floor appeared to be warped and was also soft when (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stepped on. Inside the entrance of the shower room there was about two and a half to three feet of tile missing from the baseboard of the shower room. The wall behind the missing tile was also damaged. There were four to five gouges missing from the wall. There was four to five inches of wall completely missing. There were pieces of the wall sitting crumbled on the floor. Inside the shower room stall the floor was wet from a leak that was dripping from the ceiling from a small hole (approximately one inch by one inch), the tiled floor was visibly wet. There was about a foot to a foot and a half of cracked tile inside the shower stall. On 6/24/26 at 9:50 a.m. the following was observed: Inside the Grande Heritage shower room the first and third shower stalls had coban wrapped around the shower heads and the shower head holders. On 6/24/26 at 9:57 a.m. the following was observed: Inside the Medbridge shower room stall (located on the second floor directly above the Heritage [NAME] shower room) there was a visible space (approximately half an inch) in the caulking where the floor tile meets the wall tile. C. Staff interviews CNA #3 was interviewed on 6/24/26 at 1:00 p.m. CNA #3 said the hole along the bottom of the entrance in the Heritage [NAME] shower room happened, because of equipment running into it. She said maintenance was aware of the damaged wall and had tile coming. She said she was not aware of the dripping hole in the ceiling. CNA #4 was interviewed on 6/24/26 at 1:09 p.m. CNA #4 said that she was unsure of how long the coban had been wrapped on the shower heads in Grande Heritage's first and third shower stalls. She said she thought the coban was there to help stop the leaking of the shower heads when they were being used. CNA #5 was interviewed on 6/24/26 at 1:19 p.m. CNA #5 said that the reason they used that first stall in the Medbridge shower room was because the other ones did not have the heat lights installed and the residents would get really cold without the heat lights. The maintenance director was interviewed on 6/24/26 at 2:30 p.m. The maintenance director said he was aware of the wall and ceiling outside of the Heritage [NAME] shower room. He said it was coming from the Medbridge shower room. He said he had caulked the Medbridge shower but needed to do it again. He said he was not aware that the moisture had gotten down into the lower part of the wall and the flooring outside of the Heritage [NAME] shower room. He said he was aware of the missing tiles inside of the Heritage [NAME] Shower room & the cracked tiles inside the shower stall. He said the tiles were on order and was waiting for them to come in. He said he was unaware of the leak inside the Heritage [NAME] shower stall. The maintenance director said that the shower heads and shower head holders in the first and third shower stalls in the Grande Heritage shower room, were on back order. He said he had ordered them (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was notified they were on backorder. He said he wanted the same ones as before because he did not want to add more holes in the shower stalls by having to drill different holders into the showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to revise and implement an effective discharge plan for two (#163 and #155) of three residents reviewed for discharge planning out of 62 sample residents. Specifically, the facility failed to:-Ensure the discharge planning process was documented, including the reason for discharge in Resident #163's electronic medical record (EMR); -Ensure the reconciled medication list, physician's orders and care plan provided to the resident at discharge were documented in Resident #163 and 155's EMRs;-Ensure Resident #155's discharge care plan was updated to include the resident's preference to transfer to another facility; and,-Ensure Resident #155's EMR contained documentation of the preparation provided to the resident prior to transfer to another facility in a form and manner the resident could understand. Findings include: I. Resident #163 A. Resident status Resident #163, age less than 65, was admitted on [DATE] and discharged on 10/31/25. According to the October 2025 computerized physician orders (CPO), diagnoses included acute respiratory failure, myocardial infarction (heart attack), end stage renal disease (loss of kidney function), congestive heart failure, vascular dementia (disrupted thinking caused by lack of blood flow to the brain) and metabolic encephalopathy (altered brain function). The 10/31/25 minimum data set (MDS) assessment documented in the staff assessment for resident cognition that the resident did not have a memory problem and was independent in making decisions regarding daily life. The assessment also revealed the resident needed partial to moderate assistance with activities of daily living (ADL) and was independent at meal time. The 10/31/25 MDS assessment documented the resident's discharge was an unplanned discharge and that the resident was discharged to a short-term general hospital. The assessment did not indicate the provision of the reconciled medication list to the resident at the time of discharge. -However, a review of the resident's discharge summary and staff interviews (see below) documented the resident discharged home and the discharge summary documented the resident was provided with a medication list. B. Record review The discharge care plan, initiated 10/1/25 and revised 12/19/25, documented Resident #163 would remain at the facility for long-term care due to her needing 24-hour nursing care and her family being unable to care for her at home. Pertinent interventions, initiated 10/1/25 and revised 12/19/25, included to encourage the resident's family to provide personal items as needed to create a more homelike environment; provide an arena such as interdisciplinary team (IDT) care conference for the resident, family and/or interested party to address plans for discharge and participate in the discharge planning process; review the plan of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care as needed; and social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. The 10/31/25 discharge summary and post-care instructions, provided by the nursing home administrator (NHA) on 6/24/26 at 10:00 a.m., revealed the following: The introduction documented copies of applicable documents were reviewed and provided to you (Resident #163). Please contact your primary care provider for further instructions. The discharge location was documented as home/community. The reason for discharge was documented as other, with no additional information documented as the reason for discharge. The primary care physician and the list of resources provided was not documented. The resident was documented as medically/therapeutically cleared for discharge, however the provider note on 10/30/25 failed to document any discharge notes. The records documented as provided were a medication list and care plan sent by paper (fax, copy of orders) with the resident. -However, the medication list and the care plan were not included in the discharge summary. The resident's name was typed in the signature of the receipt box but did not include a date of receipt. A review of Resident #163's EMR revealed the following: An 11/1/25 alert note documented Resident #163 was not in the facility and texted the director of nursing (DON) and staff would continue to follow up. An 11/1/25 EMR administration note documented Resident #163 was in the hospital. An 11/2/25 EMR administration note documented the resident was hospitalized . -However, according to the discharge evaluation and staff interviews (see above and below) the resident had been discharged home. C. Staff interviews The NHA, the DON, regional clinical resource #1 and regional clinical resource #2 were interviewed together on 6/25/26 at 4:00 p.m. The NHA said Resident #163 was informed she had community medicaid at her dialysis appointment and when that was communicated to the resident's niece, the niece said she would take the resident home. The NHA said the resident was to go to her appointment at the hospital and then discharge home with her niece. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the resident's name could be electronically input into the discharge evaluation but no date was added. Regional clinical resource #1 said when the facility discharged Resident #163, the resident was not taken out of the system. Regional clinical resource #1 said the facility would submit a corrected MDS assessment for Resident #163 that updated her discharge location from the hospital to home. Regional clinical resource #2 said Resident #163 was not supposed to be listed as an active resident after discharge so the nurses were documenting the resident was still in the hospital (see above). The DON said the SSD could update the discharge plan, or the nursing staff could. II. Resident #155 A. Resident status Resident #155, age less than 65, was admitted on [DATE] and discharged on 1/27/26. According to the January 2026 CPO, diagnoses included chronic respiratory failure with hypoxia (lungs cannot adequately transfer oxygen to the bloodstream), malignant neoplasm of connective and soft tissue of right lower limb, including the hip (cancer of the soft tissue), and hypothyroidism. The 1/27/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment revealed the resident needed moderate to substantial assistance for most of her ADLs. The 1/27/26 MDS assessment documented the resident's discharge was a planned discharge. The 1/27/26 MDS assessment documented the resident discharged to a skilled nursing facility. The 1/27/26 MDS assessment did not document provision of the current reconciled medication list to subsequent providers at discharge or to the resident at discharge. B. Record review The discharge care plan, initiated 5/23/25 and revised 2/1/26 (after her discharge), documented Resident #155 would remain in the facility for long-term care due to her need for 24-hour nursing care. Pertinent interventions included encouraging the resident to put personal items, as needed, in her room to create a homelike environment, reviewing the plan of care quarterly or as needed, social services to plan IDT care plan meetings upon admission, quarterly, and as needed. -However, the care was not updated to reflect the resident's preference to discharge to another facility. The 1/27/26 discharge summary and post-care instructions, provided by the NHA on 6/24/26 at 10:00 a.m., revealed the following: Resident #155's discharge location was documented as another skilled nursing facility. The reason for discharge was documented as resident preference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The records documented as provided were a medication list and care plan sent by paper (fax, copy of orders) with the resident. -However, the medication list and the care plan were not included in the discharge summary. A review of the resident's EMR revealed the following: A social services note, dated 2/19/25 at 9:59 a.m., documented that the business office assistant and the social services assistant spoke with Resident #155 about Medicaid redetermination and the need for her most recent bank statements. The note further documented that the business office assistant also spoke to the resident about the facility not receiving full payments. The note documented that the resident did not want to make full payments due to her purchasing her own food and medical supplies. -However, there were no further follow-up notes or documentation found in the resident's EMR about nonpayments. A social services note, dated 7/21/25 at 5:22 p.m., documented that Resident #155 wanted to obtain her state identification card and a copy of her social security card. The note documented that the resident hoped to discharge from the facility once she was clinically stable and she would apply for social security once she was discharged from the facility. The note documented that discharge planning was not done at that time. -However, no other follow-up notes or documentation were found in the resident's EMR about discharge plans or planning. Provider notes dated, 7/27/25, 10/23/25, 11/20/25, 12/10/25, 12/30/25 and 1/9/26 all documented, Resident #155 was planning to transition to the community within the month. The resident handled her own right hip wound by herself at the facility. She was able to manage her own finances plus other issues with the help of a transitioning team. The resident was informed she would get a three month supply of basic medications at discharge and continued to work with the facility. -However, discharge planning documentation was not found in the resident's EMR. A social services note, dated 1/22/26 at 3:40 p.m., documented that medical records and pertinent paperwork were sent per the resident's request. A social services note, dated 1/26/26 at 12:08 p.m., documented that medical records and pertinent paperwork were sent per the resident's request. -However, the note did not document the reason why records were being sent. A discharge summary note, dated 1/27/26 at 1:10 p.m., documented Resident #155 was being discharged to another facility. The note documented the resident left the facility around 12:00 p.m. with her belongings and that one of the facility's van drivers drove her to the new facility. The note documented the resident was in her wheelchair and was stable upon leaving. C. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the DON, regional clinical resource #1 and regional clinical resource #2 were interviewed together on 6/25/26 at 4:00 p.m. The NHA said that Resident #155 had not paid her share of cost and that the facility had gone to meet with her to discuss her payments. He said that Resident #155 told them that she was never going to pay her full payment. He said that they had discussed the different options and that Resident #155 was okay with being discharged to another facility. He said that Resident #155 was happy when they discussed where she would be going because they would accept her without payment. He said they had discussed the 30-day notice with the ombudsman, but because they were under the understanding that Resident #155 wanted to go, they did not notify the ombudsman when she was discharged . He said that there was no documentation of the conversations that were held with Resident #155. He said the facility should have updated Resident #155's care plan to reflect her preferences to discharge.