STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065256	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highline Post Acute	6060 E Iliff Ave Denver, CO 80222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure an environment free of accident hazards for two (#1 and #19) of nine residents reviewed for accident hazards out of 21 sample residents.On 5/18/25 Resident #1 requested certified nurse aide (CNA) #1 to heat up an egg roll from his personal refrigerator in a microwave that was at the nurses' station. After heating up the egg roll, CNA #1 gave the egg roll to Resident #1, without using a thermometer to check the temperature of the egg roll, and told the resident not to touch the egg roll because it was very hot. However, Resident #1 immediately picked up the egg roll after CNA #1 gave it to him. Hot liquid came out of the egg roll and dropped on the resident's leg causing a second degree burn to Resident #1's left thigh On 5/19/25 the facility implemented a plan of correction in response to the incident which caused Resident #1's left thigh burn. The corrective actions included placing thermometers and temperature logs at each nurses' station for staff to take the temperatures of heated up food for residents and logging the temperatures prior to giving the food to the residents. However, on 6/30/25, during the survey, observations revealed the corrective actions implemented by the facility on 5/19/25 were not in place and none of the facility's three microwaves at the nurses' stations had a thermometer or a temperature log for staff to utilize.Additionally, on 6/19/25 Resident #19 was in the facility van, in his wheelchair, for an activity outing. Resident #19 was supposed to be secured in the van with a shoulder harness seatbelt placed across his chest, which also included a seatbelt extender attached to the seatbelt. The seatbelt extender was to be secured into a hook on the van floor. However, the seat belt was not secured properly on Resident #19. During the outing, another driver in front of the van made an abrupt turn which caused the transportation driver to quickly utilize the brakes. When the transportation driver suddenly stepped on the brakes, Resident #19 fell forward out of his wheelchair, onto his knees, and scraped his forearm which caused bleeding. Resident #19 sustained a 4 centimeter (cm) by 7 cm by 0.1 cm skin tear to his right forearm.The facility investigated the incident and determined the transportation driver did not fully secure Resident #19's seatbelt, which resulted in the fall. The facility implemented a plan of correction in response to the incident on 6/19/25, immediately after Resident #19 sustained the fall in the facility van and no other incidents in the van occurred following implementation of the plan of correction. -While the facility identified and corrected the deficient practice regarding the incident with Resident #19, it was identified during the survey that the facility continued to have current deficient practice related to accident hazards due to corrective actions not being in place for the incident with Resident #1 (see above). Specifically, the facility failed to:-Ensure staff checked microwaved food for safe temperature prior to serving the food to residents, which resulted in Resident #1 sustaining a second degree burn to his left thigh; and, -Ensure Resident #19 was secured properly in the facility's van, which resulted in the resident sustaining an abrasion to his right forearm after he fell out of his wheelchair when the van abruptly stopped. Findings include: I. Burn incident with Resident #1 on 5/18/25A. Facility policy and procedureThe Hot Liquid Safety policy, dated 2025, was provided by the nursing home administrator (NHA) on 7/1/25 at 1:37 p.m. via email. It revealed in pertinent part, Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions. Proper (safe and appetizing) temperature means both appetizing to the resident and minimizing the risk for scalding and burns. Scalding is a burn caused by spills, immersion, splashes, or contact with hot water, food and hot beverages, or steam. Hot liquids can cause scalding and burns. The degree of injury depends on the temperature, the amount of skin exposed, and the duration of exposure. The temperatures of hot liquids will be checked in the dietary department or at the nurses' station if the microwave is in place before distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit (F), hold the liquid in the dietary department until it reaches an appropriate temperature. II. Resident #1 A. Resident statusResident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE] According to the June 2025 computerized physician orders (CPO), diagnoses include type 2 diabetes mellitus, dependence on renal dialysis, morbid obesity, peripheral vascular disease, history of falling, acquired absence of the right leg above the knee and acquired absence of the left leg below the knee. The 4/4/25 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. He required set up or clean up assistance with eating. He required partial moderate assistance with toileting.B. ObservationsOn 6/30/25, beginning at 2:00 p.m., three microwaves were observed in the facility, one at each of the two nurses' stations and one in the