

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Highline Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>50219</p> <p>Based on observations, record review and interviews, the facility failed to ensure a phone was consistently available and functional for resident use on two of two units.</p> <p>Specifically, the facility failed to consistently provide operational phones for residents to use from their rooms or other private areas and relay messages left for residents.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Communications Within and External to the Facility policy, dated 2024, was received from the nursing home administrator (NHA) on 8/15/24 at 6:14 p.m. It read in pertinent part, The facility will protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility.</p> <p>The facility will provide reasonable access to a telephone.</p> <p>Reasonable access means that telephones, computers and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities, such as hearing or vision loss.</p> <p>II. Resident interviews</p> <p>Resident #47 was interviewed on 8/12/24 at 10:30 a.m. Resident #47 said she never received the messages that were left for her on the voicemail on the phone at the nurse's station. Resident #47 said she used to have a phone in her room but the facility disconnected the lines. Resident #47 said the phones at the nurse's stations were often missing and it was hard to find a phone to call her family. Resident #47 said she felt cut off from her family and friends.</p> <p>Resident #47 was interviewed a second time on 8/14/24 at 2:36 p.m. Resident #47 said the phone in her room was disconnected two months prior. Resident #47 said the facility did not give the residents notice prior to the phones being taken out, but the facility staff told them how to use the facility phones if they asked.</p> <p>III. Resident council interview</p> <p>(continued on next page)</p>

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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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Residents who frequently attended monthly resident council meetings and the resident council president (#79, #47, #84 and #68) were interviewed on 8/13/24 at 2:30 p.m. The residents were identified as alert and oriented through facility and assessment. Resident #68 and Resident #47 said the residents that used the facility phones did not have privacy and had to stand at the desk and speak in front of everyone at the nurse's station.</p> <p>Resident #68 said the residents who were bedridden could not get to the nurse's station to make a phone call. Resident #68 said many residents wanted to make phone calls but could not do so. Resident #68 said there was a landline phone in the facility library but the library was too busy to take private phone calls. Resident #68 said the facility administration team used the library for their meetings and the residents at the facility did not have access to the room they needed or preferred.</p> <p>Resident #47 said since the phones were removed from resident rooms she had been cut off from her family and she had not talked to her cousin in two months. Resident #47 said her family could not get ahold of her and could not directly call her. Resident #47 said she never received messages whenever her family called her.</p> <p>IV. Observations</p> <p>On 8/15/24 at 10:33 a.m. a sign was observed near the reception desk at the facility. The sign read in pertinent part, New resident phones at each nurse's station. They are for residents and family only, this is for families to call their loved ones and for residents that need to use the phone to call out. Feel free to give family members a call. Please answer them when they ring, it is for a resident. The sign listed four phone numbers for each unit's phone line.</p> <p>At 12:23 p.m. the cordless phone at the Union nurse's station was not observed on the phone charger or at the nurse's station desk.</p> <p>-The assistant director of nursing (ADON), who was at the nurse's station did not know where the phone was and did not think a resident had it.</p> <p>V. Record review</p> <p>A grievance form, dated 4/8/24, revealed a resident's representative had concerns that the nurses at the Union nurse's station were not answering the phone or returning messages. On 4/11/24 a maintenance request ticket was put in with the maintenance department to check the phone systems as the phones were intermittently not working. The grievance was resolved on 4/15/24 with a note that said the phones were working and the resident's representative was able to get through to the nurse's station.</p> <p>A grievance form, dated 6/6/24, revealed a resident wanted a new phone system. The resident said the phones at the nurse's stations were not charged, the buttons were too small and there was not enough privacy. The grievance was resolved on 6/6/24, with the resolution being that the resident could use the phone in the library.</p> <p>-However, residents felt the library was not private enough for resident phone conversations and was not always accessible to the residents (see group interview above).</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>VI. Staff interviews</p> <p>Certified nurses aide (CNA) #4 was interviewed on 8/15/24 at 10:19 a.m. CNA #4 said there were phones available for the residents at each nurse's station. CNA #4 said the residents' families called the reception desk at the facility and it was then transferred to the appropriate unit. CNA #4 said the nurse at the station answered the calls and diverted the call to residents from there.</p> <p>Licensed practical nurse (LPN) #4 was interviewed on 8/15/24 at 10:49 a.m. LPN #4 said there were cordless phones at each nurse's station. LPN #4 said the residents came to the nurse's station to get the phone or the nurse brought it to the resident if they could not get out of bed. LPN #4 said once the receptionist transferred the call to the unit, the facility receptionist went to the unit and stood there until the nurse answered the phone. LPN #4 said the facility receptionists took messages and gave them to the unit nurse to pass onto the respective resident.</p> <p>Receptionist #1 was interviewed on 8/15/24 at 12:08 p.m. Receptionist #1 said residents had a phone at each unit. Receptionist #1 said the facility receptionists took messages and gave them to the nurse on the unit or the resident themselves.</p> <p>The social services director (SSD) was interviewed on 8/15/24 at 12:14 p.m. The SSD said resident phone calls came through the reception desk and were diverted to whichever unit the resident resided on. The SSD said the unit nurse either took a message or gave the phone to the resident to take the call. The SSD said the unit phones were put in place around six months prior, and before that, there were phone lines in each residents' room. The SSD said she did not know why the phone lines were taken out of the residents' rooms. The SSD said she had received some grievances regarding family members leaving messages that were not followed through or not being able to get their call through to the cordless phone.</p> <p>-However, residents continued to feel as though they did not have adequate access or privacy to make phone calls (see resident interviews above).</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064</p> <p>Based on record review and interviews, the facility failed to ensure one (#2) of three residents out of 46 sample residents received treatment and care in accordance with professional standards of practice.</p> <p>Specifically, the facility failed to ensure Resident #2's insulin (medication used for blood glucose) was consistently administered in a timely manner per the physician's orders.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment.</p> <p>Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:</p> <ol style="list-style-type: none"> 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. <p>II. Facility policy</p> <p>The Administering Medications policy and procedure, revised December 2012, was received from the regional director of clinical services (RDCS) on 8/15/24 at 1:36 p.m. It revealed in pertinent part, Medications shall be administered in a safe and timely manner and as prescribed.</p> <p>If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record (MAR) space provided for that drug and dose.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: the date and time the medication was administered.</p> <p>III. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included acute respiratory failure (disrupted oxygen exchange), [NAME]-chiari syndrome (structural abnormality in the skull that causes part of the brain to move into the spinal canal), spina bifida (abnormality affecting the spine), hydrocephalus (cerebral fluid build up in the spine) and type 2 diabetes (abnormal glucose).</p> <p>The 7/11/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 12 out of 15.</p> <p>The assessment revealed the resident had received seven insulin injections during the assessment period.</p> <p>B. Resident interview</p> <p>Resient #2 was interviewed on 8/12/24 at 11:03 a.m. Resident #2 said he received an insulin injection every evening. Resident #2 said he was not sure what the administration time of his insulin was because he received his injections at different times. Resident #2 said not all nurses followed his administration times and he was lucky he had not had any issues with his blood sugars yet.</p> <p>C. Record review</p> <p>The August 2024 CPO documented the following physician's order for insulin:</p> <p>Lantus (insulin glargine) inject 25 units subcutaneously in the evening for type two diabetes. Give half dose (12) units if the resident is not eating by mouth/not eating and notify the provider, ordered 5/1/24.</p> <p>Review of the August 2024 medication administration record (MAR) revealed the following:</p> <p>The Lantus insulin 6:00 p.m. dose was not administered timely on the following days:</p> <p>-On 8/2/24, the medication was administered at 8:30 p.m., one hour and 30 min after the allowed administration time;</p> <p>-8/6/24, the medication was administered at 7:30 p.m., 30 minutes after the allowed administration time;</p> <p>-8/10/24, the medication was administered at 9:40 p.m.,two hours and 40 minutes after the allowed administration time;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-8/11/24, the medication was administered at 11:53 p.m., four hours and 53 minutes after the allowed administration time; and,</p> <p>-8/13/24, the medication was administered at 7:38 p.m., 38 minutes after the allowed administration time.</p> <p>IV. Staff interviews</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 10:13 a.m. She said medications could be administered one hour before or one hour after the scheduled administration times. LPN #1 said anything outside the allowed administration time window was not considered safe. LPN #1 said the physician should be notified about the late administration to see if it was still safe to be administered. LPN #1 said the nurse should write a progress note to document the physician was called and how the resident responded to having received the medication late.</p> <p>LPN #1 said insulin medications were important to administer on time because it could impact the resident negatively by not controlling the blood glucose levels effectively.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 12:18 p.m. The DON said medications could be safely administered 30 minutes before or 30 minutes after the scheduled administration time window.</p> <p>-However, the 30 minutes before and 30 minutes after the scheduled administration time was different from the one hour before and one hour administration time window that LPN #1 said was acceptable.</p> <p>The DON said the physician should be notified of any medications administered outside the safe to administer window and nurses were to document in a progress note that the physician was contacted. The DON said administering an insulin medication late could lead to blood glucose levels being too high.</p> <p>The DON reviewed the administration times for Resident #2's Lantus insulin(see record review above) and said she believed the insulin was given on time but the nurses had documented the administration late. The DON said she believed it was just a late documentation error because the evening nurses, who administered the insulin, should have already passed the medication cart and keys off to the night shift nurses by the time the insulin was documented as given.</p> <p>The DON said the nurse should have documented the administration time at the time it was given as the record documents the medication being given late to the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services for two (#23 and #46) of four residents reviewed for ADLs out of 46 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #23 and Resident #46 received timely repositioning and toileting/incontinence care; and, -Ensure Resident #23 received proper assistance with meals, snacks and hydration. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Urinary Continence and Incontinence - Assessment and Management policy, revised August 2022, was provided by the nursing home administrator (NHA) on 8/15/24 at 1:30 pm. It read in pertinent part, The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, Including: implementing a fluid and/or bowel management program to meet assessed needs.</p> <p>II. Resident #23</p> <p>A. Resident status</p> <p>Resident #23, over the age of 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included dementia, major depressive disorder, anxiety, protein-calorie malnutrition, contracture of the right hand and severe bilateral glaucoma (high eye pressure).</p> <p>The 7/11/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. She was totally dependent on staff for care for oral hygiene, toileting hygiene, bathing, transfers and dressing below the waist, including footwear. She needed substantial/maximum assistance with eating, dressing above the waist, eating, personal hygiene and moving from a lying to sitting position in bed.</p> <p>The assessment indicated Resident #23 used a wheelchair for mobility.</p> <p>B. Observations</p> <p>During a continuous observation of the lunch meal service in the secure unit on 8/13/24, beginning at 10:16 a. m. and ending at 1:00 p.m., the following was observed:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 10:45 a.m. Resident #23 was seated in her wheelchair at a dining room table and yelled out. Two unidentified staff members were seated in the dining room but did not speak to or offer redirection to Resident #23.</p> <p>At 10:50 a.m. Resident #23 was sitting with her eyes closed and appeared to be sleeping.</p> <p>At 11:10 a.m. an unidentified staff member offered a snack to a resident seated next to Resident #23, however Resident #23 was not offered a drink or snack.</p> <p>At 11:55 a.m. the lunch meal cart arrived at the secure unit.</p> <p>At 12:01 p.m. the facility staff began serving residents their meal trays.</p> <p>At 12:05 p.m. a meal tray was placed on the dining room table in front of Resident #23.</p> <p>At 12:16 p.m. Resident #23 remained seated at the front dining room table while the facility staff assisted other residents with their lunch meals.</p> <p>At 12:24 p.m. an unidentified staff member placed a divided plate of puree food in front of Resident #23.</p> <p>At 12:28 p.m. CNA #3 was seated on Resident #23's left side. A white towel was draped over Resident #23's shoulders and chest. The white towel had fallen off her right shoulder and only partially covered her left shoulder. CNA #3 assisted Resident #23 during meal time and offered her a bite of food. CNA #3 turned away from Resident #23 to talk to CNA #1 seated next to him. While CNA #3 spoke to CNA #1, Resident #23's head leaned forward to her left and her food spilled from her mouth onto her shirt and the towel draped over her.</p> <p>At 12:29 p.m. CNA #3 offered Resident #23 a drink of lemonade. While Resident #23 took a drink of lemonade, the beverage spilled from her mouth down the front of her sweatshirt. CNA #3 continued to assist Resident #23 with her meal and speak to CNA #1 after offering Resident #23 bites of food.</p> <p>At 12:36 p.m. CNA #3 offered Resident #23 bites of her oral nutritional supplement.</p> <p>At 12:44 p.m. CNA #3 continued to assist Resident #23 and was offering her bites of her supplement. The white towel that was covering the resident's shirt fell down into her lap and pieces of food were on her shirt and the towel in her lap.</p> <p>At 1:50 p.m. Resident #23 was sitting in her wheelchair at the front dining room table, with the same towel in her lap and food on her shirt that had fallen on her an hour prior.</p> <p>During a continuous observation in the secure unit on 8/14/24, beginning at 9:15 a.m. and ending 1:03 p.m. the following was observed:</p> <p>At 9:15 a.m. Resident #23 was seated in her wheelchair at a dining room table.</p> <p>At 9:22 a.m. Resident #23 was assisted from the table in her wheelchair so the floor under the table could be swept and mopped. Resident #23 remained in the dining room seated in her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 9:31 a.m. Resident #23 was assisted back to the front table in her wheelchair.</p> <p>At 10:18 a.m. activities assistant (AA) #1 began offering coffee to residents in the dining room.</p> <p>-Resident #23 was not offered a drink during this time.</p> <p>At 10:57 a.m. a resident seated at the same table as Resident #23 was offered water and a snack.</p> <p>-However, Resident #23 was not offered a drink or snack.</p> <p>At 11:06 a.m. Resident #23 was seated in her wheelchair leaning forward with her eyes closed.</p> <p>At 11:11 CNA #3 offered snacks to residents in the dining room.</p> <p>-However, Resident #23 was not offered a snack.</p> <p>At 11:20 a.m. Resident #23 lifted the left side of her shirt to her mouth and began to chew on her shirt.</p> <p>At 11:38 a.m. Resident #23 continued to sit at the front table with her head down.</p> <p>At 11:55 a.m. Resident #23 continued to sit in her wheelchair and lifted the left side of her shirt to her mouth and began to chew on her shirt again. Resident #23 continued to chew on her shirt periodically until 12:01 p. m. leaving a wet spot on the front of her shirt approximately five inches long.</p> <p>At 12:04 p.m. the lunch meal cart arrived at the secure unit.</p> <p>At 12:09 p.m. Resident #23 was still seated in her wheelchair, she lifted the left side of her shirt to her mouth and began to chew on her shirt. Resident #23 continued to chew on her shirt until 12:11 p.m.</p> <p>At 12:24 p.m. CNA #3 placed a towel over Resident #23's shoulders and chest and then assisted Resident #23 to her room in her wheelchair.</p> <p>-Resident #23 sat in her wheelchair in the dining room for over three hours, was not repositioned or redirected and was not offered a snack or drink when other residents in the dining room were offered a snack or drink. The resident was not offered checked during the timeframe for incontinence.</p> <p>At 12:41 p.m. CNA #3 assisted Resident #23 back to the dining room; Resident #23 was wearing a different set of clothes, including a dry shirt.</p> <p>C. Record review</p> <p>Resident #23's ADL care plan, revised 6/25/2020, documented she had an ADL self-care performance deficit related to her diagnoses of dementia, confusion, imbalance and blindness Pertinent interventions included for staff to assist with ADLs as needed, revised 2/18/23.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #23's discharge care plan, revised 10/17/23, documented she would stay long term in the facility due to her vision problems and dementia and did not wish to be discharged . Pertinent interventions included to offer and frequently reposition the resident while in the wheelchair as tolerated, revised 9/12/23.</p> <p>Resident #23's skin care plan, revised 10/6/21, documented she had a potential for skin/pressure injury development due to decreased mobility, a history of fractures, incontinence and dementia. Pertinent interventions included to instruct and assist the resident to shift weight in her wheelchair often, revised 2/18/23</p> <p>Resident #23's bowel and bladder incontinence care plan, revised 7/13/22, documented she was incontinent of bowel and bladder. Pertinent interventions included encouraging the resident to drink fluids during the day to promote voiding responses (11/15/19) and to routinely check and change the resident and assist the resident upon rising, before and after the meal, before bedtime and as needed (6/28/21).</p> <p>Resident #23's malnutrition care plan, revised 2/29/24, documented she was at risk due to her diagnoses of dementia, severe stage bilateral open angle glaucoma, high blood pressure, chronic kidney disease, bilateral cataracts, anxiety and depressed mood and protein calorie malnutrition. Pertinent interventions included assisting the resident with meals and fluids as needed, catering to the resident's food preferences, encouraging adequate nutrition and hydration and the resident was unable to retain nutrition education due to dementia, all revised 10/13/23.</p> <p>Resident #23's certified nurse aide (CNA) task schedule for August 2024 (8/1/24 to 8/15/24) documented staff were to offer and reposition Resident #23 while she was in her wheelchair every two hours as tolerated.</p> <p>-The task was marked completed three times on 8/13/24 and three times on 8/14/24, however the task was not marked completed between the hours of 6:30 a.m. to 1:30 p.m. on either day.</p> <p>D. Staff interviews</p> <p>CNA #2 was interviewed on 8/15/24 at 10:46 a.m. CNA #2 said a resident who was on the check and change program should be checked for incontinence episodes at least every two hours. CNA #2 said Resident #23 was a dependent resident who always needed assistance with toileting, repositioning and changing her clothes.</p> <p>CNA #2 said Resident #23 should be offered puree snacks that included applesauce, pudding and ice cream. CNA #2 said she had been trained to assist residents at meal time and the staff should always face the resident and observe the resident during meal time. CNA #2 said Resident #23 needed assistance at meals and usually needed to be fed during meal time. CNA #2 said Resident #23 was provided a towel to place over her torso to keep her clean during meals and discourage Resident #23 from chewing on her shirts and leaving a wet mark.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The director of nursing (DON) was interviewed on 8/15/24 at 1:30 p.m. The DON said the CNAs received training that covered how to assist residents at meal time. The DON said the CNA should sit down next to the resident and assist the resident as needed, the staff should face the resident and, immediately after meal time, the resident should be helped with hygiene and the removal or changing of clothing protectors.</p> <p>The DON said residents who were on the check and change program did not have to be checked every two hours, and instead could be checked every four hours or longer if the resident did not prefer to be woken up during the night. The DON said if a resident was on a repositioning program and/or a check and change program it should be included in the resident's care plan. She said the care plan task went on the kardex (CNA task list).</p> <p>50219</p> <p>III. Resident #46</p> <p>A. Resident status</p> <p>Resident #46, age 69, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included unsteadiness on feet, abnormalities of gait and mobility and need for assistance with personal care.</p> <p>The 6/28/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. The resident required partial to moderate assistance with all activities of daily living (ADL). The resident was frequently incontinent of both bowel and bladder.</p> <p>B. Resident interview</p> <p>Resident #46 was interviewed on 8/12/24 at 10:29 a.m. Resident #46 said the facility staff did not want to assist her with incontinence care sometimes.</p> <p>C. Observations</p> <p>On 8/13/24 Resident #46's room was observed during a continuous observation, beginning at 9:56 a.m. and ending at 1:10 p.m. The following was observed:</p> <p>At 10:11 a.m. an unidentified nurse checked in on Resident #46 and asked if she was dry. Resident #46 said she was just changed.</p> <p>At 11:11 a.m. an unidentified activities aide came into Resident #46's room to offer her popcorn.</p> <p>At 11:38 a.m. an unidentified CNA checked in with Resident #46 and asked if she needed any ice water. Resident #46 declined.</p> <p>At 12:01 p.m. an unidentified activities staff member walked into Resident #46's room to speak with her roommate. The staff member said hello to Resident #46 briefly before leaving the room.</p> <p>At 12:28 p.m. an unidentified CNA delivered a lunch tray to Resident #46's roommate. Resident #46 was observed to be asleep in her chair.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 12:30 p.m. an unidentified CNA delivered a lunch tray to Resident #46.</p> <p>At 12:32 p.m. Resident #46 initiated her call light.</p> <p>At 12:35 p.m. the DON answered the call light. Resident #46 requested silverware, which the DON retrieved for the resident.</p> <p>At 1:06 p.m. an unidentified CNA retrieved Resident #46's lunch tray.</p> <p>At 1:08 p.m. Resident #46 initiated her call light</p> <p>At 1:10 p.m. CNA #4 went into Resident #46's room and shut the door (see interview below).</p> <p>D. Record review</p> <p>The incontinence care plan, revised 10/6/23, revealed Resident #46 had mixed bladder incontinence due to a history of urinary tract infections and impaired mobility. Pertinent interventions included establishing voiding patterns and monitoring/documenting intake and output per facility policy.</p> <p>The communication care plan, revised 10/6/23, revealed Resident #46 had communication problems resulting from hearing deficits. Pertinent interventions included anticipating and meeting Resident #46's needs, asking yes or no questions when appropriate and using simple, brief and consistent words and cues when communicating.</p> <p>The cognitive impairment care plan, revised 7/12/24, care plan revealed Resident #46 had cognitive loss related to altered cognitive performance. Pertinent interventions included anticipating needs and meeting them promptly.</p> <p>The 4/29/24 bowel and bladder assessment revealed Resident #46 had a neurogenic bladder and was on the check and change program. The assessment revealed Resident #46 required one-person assistance for mobility and she was usually bed-bound.</p> <p>The 7/19/24 nursing summary revealed Resident #46 was on the check and change program.</p> <p>The 7/30/24 nursing summary revealed Resident #46 was on the check and change program. The summary revealed Resident #46 was incontinent and she sometimes called the nursing staff in to change her. Resident #46 was very hard of hearing and nursing staff had to raise their voice and get close so the resident could lip read when communicating.</p> <p>E. Staff interviews</p> <p>CNA #4 was interviewed on 8/13/24 at 1:17 p.m. CNA #4 said Resident #46 used her call light to be changed. CNA #4 said Resident #46 used her call light whenever she needed to be changed. CNA #4 said Resident #46 had been incontinent of both bowel and bladder during the care provided just before the interview.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #4 was interviewed a second time on 8/15/24 at 10:19 a.m. CNA #4 said the check and change program meant the residents were checked and changed every two hours. CNA #4 said this frequency did not vary by resident and was consistent across the board, meaning every resident had to be checked at least every two hours. CNA #4 said she was not sure where these checks were recorded in the resident's electronic medical record (EMR).</p> <p>-However, a continuous observation revealed Resident #46 was not checked or changed for over three hours (see observations above).</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 11:47 a.m. LPN #1 said the check and change program was used for residents who were incontinent. LPN #1 said the CNAs did not have an established time-frame for the check and change program, but they knew they needed to check the residents and have their schedule established for the day.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150</p> <p>Based on observation, record review and interviews, the facility failed to ensure one (#24) of two residents with limited mobility reviewed for range of motion (ROM) out of 46 sample residents received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Specifically, the facility failed to ensure Resident #24 was provided with a restorative nursing program as was recommended by the director of rehabilitation (DOR).</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Restorative Nursing Services policy, revised July 2017, was provided by the nursing home administrator (NHA) on 8/15/24 at 1:31 p.m. It read in pertinent part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.</p> <p>Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (example physical, occupation, or speech therapies).</p> <p>Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.</p> <p>Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.</p> <p>The resident or representative will be included in determining goals and the plan of care.</p> <p>Restorative goals may include, but are not limited to, supporting and assisting the resident in:</p> <p>adjusting or adapting to changing abilities, developing, maintaining or strengthening his/her physiological and psychological resources, maintaining his/her dignity, independence and self-esteem and participating in the development and implementation of his/her plan of care.</p> <p>II. Resident #24</p> <p>A. Resident status</p> <p>Resident #24, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician's orders (CPO), diagnoses included chronic obstructive pulmonary disorder (COPD), type 2 diabetes mellitus, acute and chronic respiratory failure with hypoxia (deficiency for oxygen reaching the brain), dizziness, unsteadiness on feet, depression and shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/9/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mentals status (BIMS) score of 12 out of 15. He was dependent on staff for toileting and personal hygiene. He required moderate assistance with mobility.</p> <p>B. Resident interview</p> <p>Resident #24 was interviewed on 8/14/23 at 9:46 a.m. Resident #24 said he hoped to get stronger to return to independent living. Resident #24 said he had eight sessions of physical therapy upon admission. He said the therapy sessions had stopped on 6/7/24 after he was hospitalized and he was not told why. He said he would like to continue with therapy and walk independently. The resident said he was not receiving a restorative nursing program The resident said he used a wheelchair for mobility.</p> <p>C. Record review</p> <p>Physical therapy documentation was requested from the DOR on 8/15/24 at 9:50 a.m. The facility did not provide the physical therapy documentation</p> <p>The activities of daily living (ADL) care plan, revised 5/9/24, revealed the resident had a self care performance deficit. The interventions included for physical and occupational therapy to evaluate and provide treatment per the physician's order.</p> <p>The resident had a physician's order for a physical therapy evaluation and treatment, ordered on 6/13/24.</p> <p>A restorative nursing program referral was completed by the DOR on 6/13/24.The referral documented the restorative nursing program would include a range of motion (ROM) and a transfer program. The program and the program frequency included ROM and strengthening of the lower extremity, straight leg raises, hip abduction in the spine, shoulder flexion and two sets of ten repetitions of upper body rows using a three pound weight.</p> <p>-A review of the resident's electronic medical record (EMR) did not reveal documentation indicating a restorative nursing program was in place.</p> <p>D. Staff interviews</p> <p>The DOR was interviewed on 8/14/24 at 10:11 a.m. The DOR said he made a referral for a restorative nursing program for Resident #24 to be initiated with an effective date of 6/14/24. The DOR said he did not see any documentation in the resident's EMR that the program had been implemented. The DOR said he did not know the reason there was no documentation or why the program had not been implemented.</p> <p>The DOR was interviewed again on 8/15/24 at 9:45 a.m. The DOR said the restorative nurse aides (RNA) should have implemented the program. The DOR said he would speak with the director of nursing (DON) to review and monitor all restorative nursing programs.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RNA #1 was interviewed on 8/14/24 at 11:41 a.m. RNA #1 said she had not been working with Resident #24. She said she had seen the referral for the program but had not been told by anyone to initiate the program. RNA #1 said she had been trained and felt comfortable completing ROM exercises and transfers with the resident.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 2:15 p.m. The DON said she was in charge of the restorative nursing program. She said there were two trained RNAs that were currently working at the facility. She said Resident #24 should have received restorative nursing care and the resident's plan of care should have been updated to include this service. The DON said she would immediately educate RNAs and monitor all restorative programs.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150</p> <p>Based on observations, record review and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for two (#19 and #24) of three residents reviewed for respiratory care out of 46 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #19 and #24 received oxygen therapy in accordance with their physician's orders.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Oxygen Administration policy, revised October 2010, was provided by the director of nursing (DON) on 8/15/24 at 1:31 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidelines for safe oxygen administration.</p> <p>Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>Review residents' care plans to assess for any special needs of residents.</p> <p>II. Resident #19</p> <p>A. Resident status</p> <p>Resident #19, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, need for assistance with personal care, chronic pain, major depressive disorder, and fibromyalgia.</p> <p>The 6/7/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. She required supervision with touch assistance and verbal cues for transfers, dressing, toileting, personal hygiene and set-up assistance with eating and dressing.</p> <p>The assessment documented the resident was receiving oxygen.</p> <p>B. Observations</p> <p>On 8/12/24 at 9:48 a.m. Resident #19's nasal cannula (tubing device that supplies oxygen through the nose) was in her nose connected to a room oxygen concentrator with a setting of 3 liters per minute (LPM).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24 at 11:50 a.m. the resident was lying in bed. The oxygen concentrator was on and was set at 3 LPM of oxygen via nasal cannula. The nasal cannula was in the resident's nose.</p> <p>On 8/14/24 at 2:35 p.m., licensed practical nurse (LPN) #5 assisted Resident #19 to perform a routine breathing exercise. LPN #5 placed a pulse oximetry reader (device used to measure the level of oxygen in a person's blood) on the resident's right index finger to check her oxygen and heart rate levels. The device registered a measurement of 94 percent (%) oxygen saturation.</p> <p>Resident #19's oxygen saturation levels dropped below 90%, to 83%, during the respiratory treatment. LPN #5 stayed in the resident's room to ensure the resident's oxygen levels returned to above 90%.</p> <p>On 8/15/24 at 10:15 a.m. the resident was receiving oxygen at 3 LPM via nasal cannula.</p> <p>C. Resident interview</p> <p>Resident #19 was interviewed on 8/13/24 at 11:04 a.m. The resident said she did not know the number of liters of oxygen she was receiving. She said the facility staff controlled the oxygen concentrator settings. She said the oxygen helped her to breathe better.</p> <p>D. Record review</p> <p>The respiratory care plan, revised 12/13/23, documented Resident #19 had altered respiratory status and difficulty breathing related to COPD and shortness of breath while laying flat. Care plan interventions included the resident's participation in a respiratory program to enhance functionality. Further interventions included applying oxygen via nasal cannula at 4 LPM continuously and administering medications as ordered by the physician.</p> <p>The August 2024 CPO documented a physician's order for oxygen at 4 LPM via nasal cannula continuously to keep the resident's oxygen saturation level at or above 90%, ordered on 8/2/24.</p> <p>A review of the August 2024 electronic medical record (EMR) from 8/2/24 to 8/15/24 revealed the licensed nursing staff documented the resident was receiving 4 LPM of oxygen via nasal cannula.</p> <p>-However, observations on 8/12/24, 8/13/24, 8/14/24 and 8/15/24 revealed Resident #19 was receiving 3 LPM, not 4 LPM as was ordered by the physician.</p> <p>III. Resident #24</p> <p>A. Resident status</p> <p>Resident #24, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included COPD, type 2 diabetes mellitus, acute and chronic respiratory failure with hypoxia (deficiency for oxygen reaching the brain), dizziness, unsteadiness on feet, depression and shortness of breath.</p> <p>The 5/9/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He was dependent with toileting and personal hygiene and required moderate assistance with mobility.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The assessment did not indicate the resident was receiving oxygen therapy.</p> <p>B. Observations</p> <p>On 8/12/24 at 11:16 a.m. Resident #24 was lying in bed watching television with an oxygen cannula on the right side of his bed. The resident's oxygen concentrator was set to 3 LPM.</p> <p>-However, the resident had a physician's order for 2 LPM of oxygen continuously (see record review below).</p> <p>On 8/13/24 at 1:31 p.m. Resident #24 remained in bed with his oxygen concentrator set at 3 LPM. The nasal cannula was connected to the oxygen concentrator and was in the resident's nose.</p> <p>On 8/14/24 at 12:34 p.m. Resident #24 was observed sitting upright in bed in his room preparing to eat lunch. Resident # 24's nasal cannula was in his nose and was connected to the oxygen concentrator. The oxygen concentrator was set at 3 LPM. While eating lunch, the resident started to experience difficulty breathing. Resident #24 used the remote control of the bed to recline his bed down, catching deep breaths several times, for approximately two minutes before he was able to continue eating.</p> <p>C. Resident interview</p> <p>Resident #24 was interviewed on 8/14/24 at 1:00 p.m. The resident said several times during meal times he had experienced difficulty swallowing and that it had affected his breathing. He said he was supposed to be receiving continuous oxygen at 2 LPM via nasal cannula. The resident said he was unable to tell how much oxygen per liter flow he was receiving because the oxygen concentrator was placed above the head of his bed. Resident #24 said the nursing staff were the ones that set the liter flow of his oxygen concentrator.</p> <p>D. Record review</p> <p>The care plan, revised 8/2/24, revealed Resident #24 was on oxygen therapy related to ineffective gas exchange and respiratory illness. Care plan interventions included oxygen settings at 2 LPM continuously via nasal cannula.</p> <p>The August 2024 CPO included a physician's order for oxygen continuously at 2 LPM, ordered 8/2/24 for oxygen at 2 LPM continuously.</p> <p>A review of the August 2024 MAR from 8/2/24 to 8/15/24 revealed the licensed nursing staff documented the resident was receiving 2 LPM of oxygen via nasal cannula.</p> <p>-However, observations on 8/12/24, 8/13/24 and 8/14/24 revealed Resident #24 was receiving 3 LPM, not 2 LPM as was ordered by the physician.</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Certified nurse aide (CNA) #8 was interviewed on 8/14/24 at 1:20 p.m. CNA #8 said the nurses communicated the oxygen flow rates for each resident to the CNAs. She said the CNAs did not adjust the oxygen settings. She said the licensed nurses set the liter flow on the residents' oxygen concentrators. CNA #8 said Resident #19's concentrator was set at 3 LPM of oxygen per nasal cannula and Resident #24's oxygen concentrator was set at 3 LPM. CNA #8 said it was important to follow the physician's orders as communicated to her by the licensed nurse.</p> <p>LPN #1 was interviewed on 8/14/24 at 1:31 p.m. LPN #1 said she was familiar with Resident #19 and Resident #24. She said nurses and CNAs were responsible for monitoring the level of oxygen each resident was receiving and ensuring it was accurate according to the physician's order. LPN #1 said both residents were on the incorrect liter flow of oxygen. LPN #1 adjusted Resident #19's oxygen concentrator to 4 LPM and Resident #24's oxygen concentrator to 2 LPM to match their physician's orders.</p> <p>LPN #4 was interviewed on 8/14/24 at 1:36 p.m. LPN #4 said Resident #24 had a physician's order for 2 LPM of oxygen continuously. LPN #4 said she was unsure why Resident #24 was on the incorrect liter flow of oxygen. She said she should have checked the liter flow at the beginning of her shift when she was administering the resident's morning medications.</p> <p>The director of nursing (DON) was interviewed on 8/14/24 at 1:45 p.m. The DON said a physician's order was required for any medication or treatment. She said, in an emergent situation, oxygen could be administered but a physician's order should be obtained within 24 hours of the change. The DON said it was the responsibility of all nursing staff to ensure residents were on the correct liter flow of oxygen at the beginning of their shift and intermittently throughout their shift.</p> <p>The DON said not following a physician's order for oxygen therapy could result in medical complications such as shortness of breath and cell damage to the brain. The DON said she initiated audits (during the survey) of all the residents receiving oxygen therapy to ensure they were on the correct liter flow of oxygen. The DON said she would provide education to all nursing staff regarding oxygen liter flow to prevent future incidents of residents receiving the incorrect liter flow of oxygen.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>40960</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five of five certified nurse aides (CNA).</p> <p>Specifically, the facility failed to complete annual performance reviews for CNA #1, CNA #2, CNA #5, CNA #6 and CNA #7 in order to determine potential training needs.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Performance Evaluations policy and procedure, revised September 2020, was provided by the regional director of clinical services (RDCS) on 8/19/24 at 1:18 p.m. It read in pertinent part,</p> <p>The job performance of each employee shall be reviewed and evaluated at least annually.</p> <p>A performance evaluation will be conducted on each employee at the conclusion of his/her 90 day probationary period, and at least annually thereafter.</p> <p>Performance evaluations may be used in determining employee's promotion, shift/position transfer, demotions, terminations, wage increases and to improve the quality of the employee's work performance.</p> <p>The written performance evaluations will contain the director's and/or supervisor's remarks and suggestions, any action that should be taken (further training), and goals.</p> <p>II. Record review</p> <p>Annual performance reviews were requested on 8/14/24 at 1:20 p.m for CNA #1 (hired on 3/31/21), CNA #2 (hired on 8/23/22), CNA #5 (hired on 12/22/22), CNA #6 (hired on 5/20/2020) and CNA #7 (hired on 5/1/14).</p> <p>-The facility was unable to provide annual performance evaluations for 2023-2024 for all five CNAs.</p> <p>-The director of nursing (DON) said the five CNAs did not have annual performance reviews and had not completed annual in-service education based on the outcome of their reviews.</p> <p>Cross-reference F947 for failure to ensure CNAs received annual training as required.</p> <p>III. Staff interviews</p> <p>The DON was interviewed on 8/15/24 at 11:50 a.m. The DON said she had just recently become the DON at the facility. She said annual performance reviews had not been completed.</p> <p>(continued on next page)</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RDCS was interviewed on 8/15/24 at 11:26 a.m. The RDCS said the annual performance evaluations had not been completed as required. She said, during the survey, the facility had put a plan in place to ensure annual performance reviews were completed timely.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>47064</p> <p>Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly according to professional standards in two of three medication carts and one of two medication storage rooms.</p> <p>Specifically the facility failed to:</p> <ul style="list-style-type: none"> -Ensure medications were properly labeled with resident names; -Ensure medications were stored according to route of administration; -Ensure food was not stored with medications; and, -Ensure medications were not stored in a dormitory style. <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Trulicity package insert, retrieved on 8/19/24 from https://uspl.lilly.com/trulicity/trulicity.html#mg,</p> <p>Store Trulicity in the refrigerator , do not freeze Trulicity. Do not use trulicity if it has been frozen.</p> <p>II. Facility policy and procedure</p> <p>The Storage of Medications policy and procedure, dated November 2020, was received from the regional director of clinical services (RDCS) on 8/15/24 at 1:36 p.m. It revealed in pertinent part, The facility stores all drugs and biologicals in a safe, secure and orderly manner.</p> <p>Nursing staff are responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>Medications requiring refrigeration are stored in refrigerators located in the drug room at the nurse's station or other secured locations. Medications are stored separately from food and are labeled accordingly.</p> <p>III. Observations and staff interviews</p> <p>On 8/14/24 at 11:01 a.m. the Cherry Creek long hall medication cart was observed with licensed practical nurse (LPN) #1. The following was observed:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>One vial of glargine insulin (used for blood glucose management) with an open date of 8/6/24.</p> <p>-The vial was not labeled with a resident's name. The vial had house stock written on the bottle.</p> <p>LPN #1 was interviewed on 8/14/24 at 11:04 a.m. LPN #1 said the glargine insulin vial was the facility's house stock for emergencies, for example when there was a new physician's order and the medication had not been delivered from the pharmacy. LPN #1 said the vial should have had the resident's name on it to identify it belonged to a certain resident as each resident should have their own vial or pen for insulin.</p> <p>On 8/14/24 at 12:13 p.m. the Capitol Hill medication cart was observed with registered nurse (RN) #1. The following was observed:</p> <p>-One vial of Lantus insulin was stored next to Latanoprost 0.005% eye drops in the medication cart.</p> <p>RN #1 was interviewed on 8/14/24 at 12:25 she said medications should be stored according to the route they were to be administered to prevent infections.</p> <p>On 8/14/24 at 12:18 p.m. the Capitol Hill medication storage room was observed with RN #1. The following was observed:</p> <p>-The medication storage refrigerator was unlocked and there were four 237 milliliters (ml) cartons of Boost (supplement drink) on the shelf with Lorazepam (antianxiety controlled medication), liquid cephalexin (antibiotic) and two boxes of Trulicity injectable pens (used for glucose control).</p> <p>-The medication refrigerator was a dormitory style refrigerator where the freezer compartment was in the main compartment of the refrigerator. The freezer compartment had built up ice around and in the freezer.</p> <p>RN #1 was interviewed on 8/14/24 at 12:25 p.m. RN #1 said there should not be food or oral nutritional supplements in the refrigerator with medications. RN #1 said the ice build up in the freezer compartment could potentially cause temperature fluctuations and medications needed to be kept within a certain temperature range.</p> <p>IV. Additional staff interviews</p> <p>The director of nursing (DON) was interviewed on 8/14/24 at 11:18 a.m. The DON said insulin vials or pens should have the resident's name on them to verify who the medication belonged to. The DON said she would pull the vial of glargine insulin from the medication cart.</p> <p>The DON was interviewed a second time on 8/15/24 at 12:14 p.m. The DON said the facility had obtained a new vial of glargine insulin to replace the glargine insulin vial that had no name on it from the Cherry Creek long hall medication cart.</p> <p>The DON said food and nutritional supplements should not be stored with medications in the medication refrigerator in order to prevent contamination. The DON said medications should be stored according to the route they were to be administered in the medication carts to prevent contamination/infection.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said dormitory style refrigerators should not be used for medication storage as their temperatures could fluctuate and compromise medications. The DON said she was not aware the facility had any dormitory style refrigerators.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>47151</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs.</p> <p>Specifically, the facility failed to ensure residents who were prescribed mechanically altered diets had food prepared according to their diet orders of puree, level five minced and moist and level six soft and bite sized as indicated on their meal tray cards.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The International Dysphagia (difficulty swallowing) Diet Standardization Initiative (IDDSI) (a tool to standardize mechanically altered diets and liquids) (January 2019), retrieved on 8/20/24 from https://iddsi.org/Resources/Patient-Handouts read in pertinent part,</p> <p>Level four pureed foods have a smooth texture with no lumps.</p> <p>The level five minced and moist texture: Meat should be served finely minced or chopped to a four millimeter (mm) (slightly larger than one eighth of an inch) lump size served in a thick, smooth, non-pouring sauce or gravy; vegetables should be cooked, finely mashed or blended to finely chop them into four mm lump size pieces. Rice requires a sauce to moisten it and hold it together. Rice should not be sticky or gluey and should not separate into individual grains when cooked and served. The rice may require a thick, smooth, non-pouring sauce to moisten and hold the rice together.</p> <p>The level six soft and bite-sized texture: Meat should be cooked tender and chopped so pieces are no bigger than one and a half centimeter (cm) by one and a half cm lump size. If the meat cannot be served soft and tender, modify and serve as a level five mince and moist product. Vegetables should be steamed or boiled with final cooked size no bigger than one and a half cm by one and a half cm (approximately one half of an inch). (Stir fried vegetables are too firm and are not suitable). Rice requires a sauce to moisten it and hold it together. Rice should not be sticky or gluey and should not separate into individual grains when cooked and served. The rice may require a thick, smooth, non-pouring sauce to moisten and hold the rice together.</p> <p>Bread: no regular dry bread, sandwiches or toast of any kind should be served for puree, level five or level six diets. Use IDDSI level five minced and moist sandwich recipe to prepare bread, use pre-gelled 'soaked' breads that are very moist and gelled through the entire thickness.</p> <p>II. Facility policy and procedure</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Therapeutic Diets policy and procedure, revised October 2017, was provided by the nursing home administrator (NHA) on 8/15/24 at 1:30 p.m. The policy read in pertinent part, Diet order should match the terminology used by the food and nutrition department. If a mechanically altered diet is ordered, the provider will specify the texture modification. The dietitian, nursing staff and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. Snacks will be compatible with the therapeutic diet. If the resident or resident's representative declines the recommended therapeutic diet, the interdisciplinary team will collaborate with the resident or representative to identify possible alternatives.</p> <p>III. Record review</p> <p>The menu extensions and modifications for modified texture diets were provided by the consulting registered dietitian (CRD) on 8/15/24 at 3:00 p.m. The menu extensions documented the following modifications for the mechanically altered food items served during lunch meal service on 8/13/24 and breakfast and lunch meal service on 8/14/24:</p> <p>The modified texture diet menu extensions for the lunch meal on 8/13/24 were documented as follows:</p> <ul style="list-style-type: none"> -Puree texture included: Puree roast beef, puree cilantro brown rice, puree carrots and puree banana cake; -Level five minced and moist texture included: Minced and moist roast beef, cilantro brown rice and minced and moist carrot and minced and moist banana cake; and, -Level six soft and bite sized texture included: Soft and bite sized roast beef, cilantro brown rice, soft and bite sized carrots and soft and bite sized banana cake. <p>The modified texture diet menu extensions for the breakfast meal served on 8/14/24 were documented as follows:</p> <ul style="list-style-type: none"> -Level six soft and bite sized texture: serve the biscuit and gravy as puree biscuit and gravy. <p>The modified texture diet menu extensions for the lunch meal on 8/14/24 were documented as follows:</p> <ul style="list-style-type: none"> -Puree texture included: Puree hamburger, puree potatoes, puree white roll and vanilla pudding; -Level five minced and moist: Minced and moist hamburger, minced and moist dice potatoes, white roll and vanilla pudding; and, -Level six soft and bite sized: Soft and bite sized hamburger, diced potatoes, white roll and vanilla pudding. <p>III. Meal service observation</p> <p>During a continuous observation of the lunch meal service in the secure unit on 8/13/24, beginning at 10:16 a. m. and ending at 1:00 p.m., the following was observed:</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The posted menu in the dining room documented the lunch meal consisted of pot roast, glazed carrots, cilantro brown rice and banana cake.</p> <p>At 11:55 a.m. the meal tray cart arrived in the secure unit.</p> <p>At 12:14 p.m. a meal tray was delivered to Resident #86 by an unidentified staff member. Resident #86's meal tray card documented she was prescribed a level six soft and bite sized diet. Resident #86 was served a meal that included roast beef, rice, and carrots sliced in one to one and a half inch pieces.</p> <p>-The facility failed to add gravy to Resident #86's rice and failed to cut Resident #86's carrots into pieces no bigger than one and a half by one and a half centimeters according to the IDDSI recommendations for a level six soft and bite sized diet (see professional reference above).</p> <p>At 12:16 p.m. a meal tray was delivered to Resident #23. Resident #23 received puree food items on a divided plate. The puree rice on Resident #23's plate appeared to have visible pieces of rice that were not blended and smooth. While assisting Resident #23 at meal time, an unidentified staff member asked Resident #23 if she liked the food and Resident #23 replied, No.</p> <p>At 12:29 p.m. Resident #81's meal tray card documented he was prescribed a level five minced and moist diet. Resident #81 was served a meal that included carrots sliced into one to one and a half inch pieces.</p> <p>-The facility failed to cut or chop Resident #81's carrots into four mm lump size pieces according to the IDDSI recommendations for a level five minced and moist diet (see professional reference above).</p> <p>At 12:24 p.m. the nutritional services director (NSD) was interviewed. The NSD was notified the carrots were cut into one inch to one and a half inch pieces. The NSD said she did not yet have full access to her menu program for menu extensions. The NSD said the carrots might be too big based on the IDDSI description and the staff usually cut the vegetables into bite sized pieces.</p> <p>At 12:29 p.m. Resident #28's meal tray card documented she was prescribed a level six soft and bite sized diet. Resident #28 was served a meal that included roast beef, rice, and carrots sliced in one to one and a half inch pieces.</p> <p>-The facility failed to add gravy to Resident #86's rice and failed to cut Resident #86's carrots into pieces no bigger than one and a half by one and a half centimeters according to the IDDSI recommendations for a level six soft and bite size diet (see professional reference above).</p> <p>At approximately 1:00 p.m. at the conclusion of the lunch meal, the puree food items provided to Resident #23 were observed to have small visible lumps in the puree entree, puree carrots and puree rice.</p> <p>-The facility failed to puree the food items in Resident #23's meal until the food was smooth with no lumps according to the IDDSI recommendations (see professional reference above).</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continuous observation in the secure unit on 8/14/24, beginning at 9:15 a.m. and ending 1:03 p.m. the following was observed:</p> <p>The posted menu in the dining room documented the breakfast meal consisted of biscuits and sausage gravy, and the lunch meal consisted of a beef gyro with cottage fries and a dinner roll.</p> <p>At 9:49 a.m. certified nurse aide (CNA) #3 delivered a meal tray to Resident #86 that included scrambled eggs and biscuits and gravy. Resident #86's meal tray card documented she was prescribed a level six soft and bite sized diet. The biscuit was served whole, lightly browned on the edges and dry on the bottom with sausage gravy over the top of the biscuit. CNA #3 cut Resident #86's biscuit into one inch pieces.</p> <p>-The facility failed to serve Resident #86 the biscuit and gravy as puree biscuit and gravy per Resident #86's level six soft and bite sized diet (see professional reference above).</p> <p>At 12:15 p.m. activities assistant (AA) #1 delivered a meal tray tray to Resident #81. Resident #81's meal tray card documented he was prescribed a level five minced and moist diet. Resident #81 received a sandwich on a bun with meat in strips approximately one inch long, a dinner roll and cottage fries (french fried potatoes with skin on).</p> <p>-The facility failed to serve Resident #81's meat finely minced or chopped to a four millimeter size, serve Resident #81's vegetables without skin and finely mashed or blended to finely chop them into four mm lump size pieces and modify his dinner roll so it was not served dry according to the IDDSI recommendations (see professional reference above).</p> <p>IV. Staff interviews</p> <p>CNA #2 was interviewed on 8/15/24 at 10:46 a.m. CNA #2 said she had received training on mechanically altered diet textures and how to recognize them. She said if a resident received an item prepared incorrectly according to their prescribed diet, she would inform the kitchen. CNA #2 said she did not see that Resident #81 was served potatoes that were not modified correctly during the 8/14/24 lunch meal.</p> <p>Dietary aide (DA) #2 was interviewed on 8/15/24 at 1:56 p.m. DA #2 said residents prescribed level five and level six mechanically altered diets should not have toast but were able to have bread with crusts removed. DA #2 said if the menu extension called for diced potatoes, those on puree and level five and level six mechanically altered diets could have mashed potatoes unless the kitchen already had diced potatoes prepared.</p> <p>Cook (CK) #1 was interviewed on 8/15/24 at 2:13 p.m. CK #1 said he worked as an agency employee but would soon be an employee of the facility. CK #1 said he had not had prior education on mechanically altered textures.</p> <p>DA #1 was interviewed on 8/15/24 at 2:14 p.m. DA #1 said the previous dietary manager said residents on soft and bite-sized texture diets could be served grilled or toasted buns.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-However, according to the IDDSI guidelines, no regular dry bread, sandwiches or toast of any kind should be served for puree, level five or level six diets. IDDSI level five minced and moist sandwich recipes should be used to prepare bread or the use of pre-gelled 'soaked' breads that were very moist and gelled through the entire thickness were appropriate.</p> <p>The NSD and the CRD were interviewed together on 8/15/24 at 2:36 p.m. The NSD said she had not had any recent training regarding mechanically altered diets but was working on refreshing her knowledge. The NSD said the kitchen staff were not too knowledgeable on what the different diet textures were and what residents on mechanically altered diets could not have.</p> <p>The CRD said the facility made an error serving potato skins on the french fries on 8/14/24. The CRD said the issue was that the facility had ordered french fries with potato skin on them. The CRD said toasting buns for residents prescribed the soft and bite-sized diet texture's hamburger buns was a mistake.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151</p> <p>Based on observations and interviews, the facility failed to provide food and drinks that accommodate resident allergies, intolerances and preferences for residents in one of two dining rooms and for one (#63) of four residents reviewed for preferences out of 46 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure residents in the secured unit were offered drinks of choice at meal time; and, -Ensure Resident #63 received the meal items that he ordered. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Resident Food Preferences policy, revised July 2017, was provided by the nursing home administrator (NHA) on 8/15/24 at 1:30 p.m. It read in pertinent part, Upon a resident's admission (or within 24 hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences. When possible, the staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review issues related to food preferences and meals to identify more widespread concerns about meal offerings, food preparation.</p> <p>II. Failure to ensure residents in the secured unit were offered drinks of choice at meal time</p> <p>A. Observations</p> <p>During a continuous observation of the lunch meal service in the secured unit on 8/12/24, beginning at 11:12 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 11:28 a.m. the lunch meal cart arrived at the secure unit.</p> <p>At 11:35 a.m. the facility staff served four residents their meal trays. Each of the four residents had a glass of cranberry juice on their meal tray.</p> <p>At 11:36 a.m. the facility staff served two residents their meal trays. Each of the two meal trays had a glass of cranberry juice on the tray.</p> <p>At 11:41 a.m. the facility staff served six more residents their meal trays. All six meal trays had a glass of cranberry juice on the tray.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-All twelve of the residents eating in the secured unit dining room had a pre-poured glass of cranberry juice sent on the meal tray cart on each resident's meal tray.</p> <p>-No other drinks were on the resident meal tray carts or offered to residents.</p> <p>During a continuous observation of the lunch meal service in the secured unit on 8/13/24, beginning at 10:16 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 11:55 a.m. the lunch meal cart arrived at the secure unit.</p> <p>At 12:01 p.m. facility staff began serving residents their meal trays.</p> <p>At 12:03 p.m. the facility staff served four residents their meal trays. Each of the four residents had a glass of cranberry juice on their meal tray.</p> <p>At 12:16 p.m. the facility staff served seven more residents their meal trays. Each resident had a glass of cranberry juice on their meal tray.</p> <p>-A total of eleven residents eating in the secured unit dining room had a pre-poured glass of cranberry juice sent on the meal tray cart on each resident's meal tray.</p> <p>-No other drinks were on the resident meal tray carts or offered to the residents.</p> <p>During a continuous observation of the lunch meal service in the secure unit on 8/14/24, beginning at 11:15 a.m. and ending at 2:00 p.m., the following was observed:</p> <p>At 12:04 p.m. the lunch meal cart arrived at the secure unit.</p> <p>Between 12:04 p.m. and 12:22 p.m. the facility staff served nine residents seated in the dining room their meal trays and each of the nine residents had a glass of cranberry juice on their meal tray.</p> <p>-A total of nine residents eating in the dining room had a glass of pre-poured cranberry juice sent on the meal tray cart on each resident's meal tray.</p> <p>-No other drinks were on the resident meal tray carts or offered to the residents.</p> <p>B. Staff interviews</p> <p>Certified nurse aide (CNA) #2 was interviewed on 8/15/24 at 10:46 a.m. CNA #2 said the staff asked the residents for their preferences. She said the residents' dislikes and allergies were listed on their care plans and the meal tickets. CNA #2 said the staff asked residents what their drink preferences were. She said if a resident was unable to choose, the facility sent the resident cranberry juice because it was good for the resident's bladders. CNA #2 said the dietary staff used to send pitchers of different juices and milk to the secure unit for meal time but no longer did so. CNA #2 said the drinks for residents living on the secure unit were poured in the kitchen and sent in the meal tray cart at meal time.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-However, staff were not observed asking residents the drink preferences during multiple meal service observations.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 1:30 p.m. The DON said the staff should offer a choice of drinks to residents and if a resident was unable to state their preferences, the staff could ask the resident's family for preferences. The DON said facility staff should be taking orders for the residents' drinks. The DON said the staff should show the residents a choice between two different beverages if that helped the resident choose. The DON said she was unsure if the residents in the secure unit all choose cranberry juice as their preferred drink.</p> <p>47064</p> <p>III. Failure to ensure Resident #63 received the correct meal items</p> <p>A. Resident #63</p> <p>1. Resident status</p> <p>Resident #63, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included acute respiratory failure (disrupted oxygen exchange), chronic kidney disease (decrease kidney function), type 2 diabetes (abnormal glucose) and hypertension (high blood pressure).</p> <p>The 6/3/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15.</p> <p>The MDS assessment indicated the resident was on a therapeutic diet.</p> <p>2. Resident interview</p> <p>Resident #63 was interviewed on 8/12/24 at 10:18 a.m. Resident #63 said he preferred to eat his meals in his room. He said he often received food items on his meal trays that he did not order and he was frequently missing items he did order. Resident #63 said he would order sugar-free options like jello and he would receive regular jello versus sugar-free jello.</p> <p>Resident #63 was interviewed again on 8/13/24 at 1:34 p.m. Resident #63 said he did not get his mashed potatoes and received rice instead for his lunch on 8/13/24. Resident #63 said nobody wanted to eat rice with pot roast.</p> <p>Resident #63 said he did not want to eat his food because it was not what he had ordered. Resident #63 said nobody informed him that the rice was being served for lunch instead of mashed potatoes.</p> <p>3. Observations and staff interviews</p> <p>On 8/13/24 at 1:34 p.m. Resident #63's lunch tray was delivered. Resident #63's lunch meal ticket indicated Resident #63 had ordered mashed potatoes with gravy, pot roast, milk and a Glucerna (supplement drink). Resident #63's lunch tray had pot roast, rice, milk and a Glucerna.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #63 received rice on his lunch tray instead of the mashed potatoes he had ordered.</p> <p>CNA #1 was interviewed on 8/13/24 at 1:41 p.m. CNA #1 said Resident #63 did not receive mashed potatoes on his plate. She said the resident received rice, pot roast, milk and Glucerna.</p> <p>CNA #1 reviewed Resident #63's meal ticket and said the resident had ordered mashed potatoes.</p> <p>-CNA #1 did not offer to get resident mashed potatoes or another alternative despite the resident's order being delivered incorrectly.</p> <p>IV. Resident group interview</p> <p>Four residents (#47, #68, #79 and #84) who were identified as interviewable by the facility and assessment, were interviewed on 8/13/24 at 2:30 p.m.</p> <p>The residents said they could circle menu items they wanted on their meal ticket but they did not always receive what they ordered. The residents said the kitchen served all of the residents the same food items. The group said the kitchen staff gave the residents what the kitchen wanted to serve and did not explain why the residents did not get what they ordered.</p> <p>V. Additional staff interviews</p> <p>The DON and the regional director of clinical services (RDCS) was interviewed on 8/15/24 at 1:30 p.m. The DON said the CNAs needed to notify the nurse or unit manager if a resident refused their meal.</p> <p>The RDCS said the facility had given education to CNAs about offering alternative menu items to residents and making sure the care plan reflected it.</p> <p>The DON and the RDCS said they were not aware residents were not receiving the alternative menu items they had requested. The DON and the RDCS said they were not aware that residents were not receiving the menu items they had requested.</p> <p>Dietary aide (DA) #2 was interviewed on 8/15/24 at 1:56 p.m. DA #2 said the CNAs took the residents' orders and were responsible for helping the residents fill out their meal tickets. DA #2 said all of the residents received the same meals despite what was written on their meal tickets.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50219</p> <p>Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the kitchen.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross contamination; -Ensure safe and appropriate storage of food items in the refrigerators and pantry; and, -Ensure safe holding temperatures for food items were maintained. <p>Findings include:</p> <p>I. Failed to ensure ready-to-eat foods were handled in a sanitary manner</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 8/20/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.</p> <p>If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</p> <p>B. Observations</p> <p>During a continuous observation of the lunch meal service on 8/13/24, beginning at 10:20 a.m. and ending at 1:40 p.m. the following was observed:</p> <p>At 10:28 a.m. dietary aide (DA) #1 began preparing sandwiches. DA #1 donned (put on) a pair of gloves and grabbed several slices of bread out of a plastic bag. DA #1 grabbed and opened a jar of mayonnaise. Using the same gloves, DA #1 held the slices of bread and applied mayonnaise. DA #1 set down the bread and opened the cold table tray lid by grabbing the handle with his gloved hand. With the same gloved hands, DA #1 picked up slices of lettuce and deli meat and set them on the sandwich.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 10:41 a.m. DA #2 donned a pair of gloves and opened the cold table tray lid by grabbing the handle. Using the same gloves, DA #2 picked up a plastic bread bag, undid the twist tie and pulled out two slices of bread. With the same gloved hands, DA #2 set the pieces of bread on the cutting board, grabbed deli meat and set it on the bread. DA #2 left the station, still wearing the same gloves, and went to retrieve a block of cheese slices out of the main walk-in refrigerator. DA #2 peeled off the plastic wrapper around the block of cheese slices. With the same gloved hands, DA #2 removed the deli slices that were on the bread, placed a cheese slice onto the bread, then replaced the deli meat on top of the cheese slice. DA #2 wiped his nose with his wrist and the back of his gloved hand, then placed the top slice of bread on the sandwich and wrapped it in plastic wrap.</p> <p>At 11:30 a.m. the lunch tray line began. Throughout the lunch service, the nutritional services director (NSD) moved the pita bread using gloved hands to make room for other items on the plate.</p> <p>-Between each tray the NSD was handling meal tickets, serving handles and tongs with the same gloved hands.</p> <p>At 12:12 p.m. cook (CK) #1 opened the steam oven using gloved hands and grabbed a plastic bag of pita bread. Using the same gloved hands, CK #1 took several pieces of pita bread out of the bag and set them on individual plates to be served.</p> <p>At 12:16 p.m. CK #1 grabbed another plastic bag of pita bread. Using the same gloved hands, CK #1 took the pita bread out of the bag and put it into the steam table bin to be served.</p> <p>-CK #1 had handled plate warmers and serving tongs using the same gloved hands prior to grabbing the pita bread bag.</p> <p>At 12:18 p.m. DA #1 was handling meal tickets using gloved hands. With the same gloved hands, DA #1 took a hotdog bun out of the plastic packaging and set it on the griddle. Using the same gloved hands, DA #1 held the hot dog bun to steady it as she put the hot dog inside. DA #1 used the same gloved hands to handle meal tickets, a serving handle, then the microwave handle. Using the same gloved hands, DA #1 again picked up the hotdog and hotdog bun and set it onto a plate.</p> <p>At 12:22 p.m. the NSD set a meal ticket on top of a lunch plate. The meal ticket was touching the hotdog bun.</p> <p>At 12:26 p.m. the NSD took the temperature of a batch of gyro meat that was cooking in the steam oven. The NSD said the temperature was eight degrees below what it needed to be and grabbed a set of tongs from the container that had cooked gyro meat in it. The NSD used the same tongs to lay the steam oven batch of gyro meat onto the griddle, then put the tongs back into the bin of cooked gyro meat on the steam table.</p> <p>At 12:59 p.m. DA #2 opened the cold table tray lid with gloved hands. Using the same gloved hands, DA #2 sifted through several pieces of lettuce before selecting a few pieces and putting them on a plate. Using the same gloved hands, DA #2 lifted another cold table tray lid and pulled out two tomato slices before putting them on the same plate.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/15/24 at 1:56 p.m. DA #2 began preparing a sandwich. DA #2 donned gloves and opened the cold table tray lid, the lid for a jar of mayonnaise and the kitchen tool drawer. Using the same gloved hands, DA #2 grabbed a slice of cheese and several slices of deli meat before setting them onto a slice of bread.</p> <p>C. Staff interview</p> <p>The NSD was interviewed on 8/14/24 at 2:50 p.m. The NSD said ready-to-eat foods should be handled with clean gloves. The NSD said gloves should be changed and hand hygiene should be performed after touching items such as tongs, meal tickets and handles to equipment.</p> <p>II. Failed to store food items correctly in the refrigerators and the dry storage</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 8/20/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices and sugar shall be identified with the common name of the food.</p> <p>In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.</p> <p>Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees celsius (41 degrees fahrenheit (f)) or less for a maximum of seven days. The day of preparation shall be counted as day one.</p> <p>B. Observations</p> <p>On 8/12/24 at 9:15 a.m. an initial walkthrough of the kitchen was conducted. The following was observed in the dry food storage area:</p> <ul style="list-style-type: none"> -There was an unlabeled undated bin of what appeared to be flour; and, -There was an unlabeled and undated container that held an open bag of rice. The rice was still in the open bag and the container did not have a lid on it. <p>On 8/13/24 at 10:25 a.m. the following was observed in the Seasons unit refrigerator:</p> <ul style="list-style-type: none"> -A used surgical mask was sitting on a container of popsicles in the freezer; -An opened and undated bag of lettuce; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An opened and undated bag of shredded cheese;</p> <p>-An opened and undated bag of tortillas;</p> <p>-A four ounce container of applesauce that was opened and undated;</p> <p>-Three unlabeled and undated sandwiches;</p> <p>-A container of store-bought pre-cut cantaloupe was on the refrigerator shelf with a use by date of 8/11/24;</p> <p>-An insulated lunch bag with no name or label was on the bottom shelf of the refrigerator; and,</p> <p>-A black backpack was on the top shelf of the refrigerator.</p> <p>-There was not a thermometer in the freezer at the time of observation.</p> <p>On 8/14/24 at 10:08 a.m. the following was observed in the main kitchen:</p> <p>-The walk-in refrigerator contained three bottles of heaving whipping cream with an expiration date of 8/13/24 and</p> <p>-In a different refrigerator, there was a carton of herbal tea with a use by date of 4/26/24.</p> <p>-In the main kitchen dry goods storage area, the same container that held an open bag of rice (initially observed on 8/12/24 - see above) was still present. The rice was still in the open bag and the container did not have a lid on it. The rice was not labeled or dated.</p> <p>On 8/14/24 at 3:05 p.m. the following was observed in the activities department refrigerator: -An open and undated jar of jelly;</p> <p>-An open and undated jar of mayonnaise; and,</p> <p>-An opened and undated jar of salsa.</p> <p>-The daily temperature log was missing entries for 8/10/24 through 8/12/24.</p> <p>On 8/14/24 at 3:10 p.m. the following was observed in the Seasons unit refrigerator:</p> <p>-Two opened and undated boxes of donuts;</p> <p>-An opened and undated bag of lettuce;</p> <p>-An opened and undated bag of shredded cheese;</p> <p>-An opened and undated bag of tortillas;</p> <p>-A container of store-brand pre-cut cantaloupe with a use by date of 8/11/24;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An opened and undated container of whipped cream;</p> <p>-An opened and undated bottle of chocolate sauce; and, two undated sandwiches.</p> <p>-The used surgical mask (see observation from 8/13/24 above) was still sitting on top of the bag of popsicles in the freezer.</p> <p>-The NSD was unable to find a thermometer in the freezer.</p> <p>On 8/14/24 at 3:18 p.m. the following was observed in the library refrigerator:</p> <p>-An open and undated bag of frozen juice and an open and undated pint of ice cream were labeled with residents names, opened, unlabeled, and undated bag of granola was at the bottom of the fridge, an unlabeled and undated squeeze bottle of an unidentified green liquid was found on the shelf of the refrigerator.</p> <p>-The NSD was unable to find a thermometer in the freezer.</p> <p>C. Staff interview</p> <p>The NSD was interviewed on 8/12/24 at 9:30 a.m. The NSD said she had ordered thermometers for all of the refrigerators and freezers at the facility the week prior.</p> <p>The NSD was interviewed a second time on 8/14/24 at 2:50 p.m. The NSD said she was not sure how often the facility refrigerators were cleaned out or checked but it was going to be part of her cleaning list and her daily walkthroughs. The NSD said she also wanted to train the facility staff on food labeling and storage.</p> <p>III. Maintain safe holding temperatures for food items</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 8/20/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part,</p> <p>Time/temperature control for safe food cold holding shall be maintained at 5 degrees Celsius (C) (41 degrees Fahrenheit) or less.</p> <p>Time/temperature control for safety food that is cooked to a temperature and for a time specified under SS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57 degrees Celsius (135 degrees Fahrenheit) or above.</p> <p>B. Observations</p> <p>On 8/14/24 at 11:21 p.m. DA #2 took the temperatures of the food items. A bin of sliced tomatoes was 45 degrees F, a bin of sliced cucumbers was 50 degrees F and a bin of tzatziki sauce (yogurt based condiment) was 52 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The temperatures of these items were above the safe temperature parameters for cold foods of 41 degrees F or less.</p> <p>At 11:26 a.m. the NSD educated DA #2 on the safe holding temperatures for cold food items and had DA #2 put the containers of tomatoes, cucumbers and tzatziki sauce into larger ice baths.</p> <p>-The temperatures of the tomatoes, cucumbers, and tzatziki sauce were not re-assessed to ensure they had reached appropriate cold-holding temperatures prior to the start of lunch service.</p> <p>At 1:22 p.m. final temperatures were taken of the foods served during lunch service. The sliced gyro meat measured 116 degrees F.</p> <p>-The temperature of this item was below the safe holding temperature parameters for hot foods of 135 degrees F or greater.</p> <p>-At 1:26 p.m. the NSD served a resident a plate of the sliced gyro meat for a resident without reheating it.</p> <p>C. Staff interviews</p> <p>DA #2 was interviewed on 8/14/24 at 11:21 p.m. DA #2 said a holding temperature of 45 degrees F for a cold food item was okay because it was over the 41 degree F measurement on their reference sheet.</p> <p>The NSD was interviewed on 8/14/24 at 2:50 p.m. The NSD said the procedure for time and temperature control for food was heating hot food again to make sure it was a safe temperature prior to serving. She said cold food items should be stored in an ice bath for service to ensure the food maintained the correct temperature. The NSD said the ideal holding temperatures for hot foods was above 135 degrees F and for cold foods was below 36 degrees F. The NSD said she did not think the steam table was holding temperatures well and she would look into ordering new equipment.</p>

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NAME OF PROVIDER OR SUPPLIER Highline Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6060 E Iliff 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219</p> <p>Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.</p> <p>Specifically, the facility failed to ensure staff followed proper infection control procedures for a resident on enhanced barrier precautions (EBP).</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 8/21/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part,</p> <p>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.</p> <p>EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>II. Facility policy and procedure</p> <p>The Enhanced Barrier Precautions policy, undated, was received from the nursing home administrator (NHA) on 8/15/24 at 6:14 p.m. It read in pertinent part, It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms.</p> <p>The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities.</p> <p>High-contact resident care activities include device care or use for feeding tubes.</p> <p>III. Resident #55</p> <p>A. Resident status</p> <p>Resident #55, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physicians orders (CPO), diagnoses included dysphagia (a swallowing disorder) and severe protein-calorie malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/24/24 minimum data set (MDS) assessment documented the resident was using a feeding tube.</p> <p>B. Observations</p> <p>On 8/12/24 at 10:45 a.m. there was no sign indicating Resident #55 needed EBP was observed on his door.</p> <p>-However, according to the resident's care plan and August 2024 CPO, Resident #55 was supposed to have a sign outside his room to indicate he was on EBP (see record review below).</p> <p>On 8/15/24 at 10:39 a.m. there was no sign outside Resident #55's room to identify the resident was on EBP. Licensed practical nurse (LPN) #4 entered Resident #55's room, washed her hands, and donned a new pair of gloves.</p> <p>LPN #4 proceeded to remove the dressing over Resident #55's feeding tube and switched the line providing enteral nutrition. LPN #4 left Resident #55's room to gather more supplies, then came back and washed her hands. LPN #4 donned a new pair of gloves, applied a wound cleansing solution to the feeding tube site and wiped it with gauze. LPN #4 applied a new dressing over Resident #55's feeding tube site, removed her gloves and used alcohol based hand sanitizer to sanitize her hands as she exited the room.</p> <p>-LPN #4 failed to wear a gown while providing care for Resident #55's feeding tube.</p> <p>-At 12:07 p.m. an EBP sign was observed on Resident #55's door and drawers containing PPE had been placed outside the resident's room.</p> <p>C. Record review</p> <p>The 6/18/24 care plan, revised 6/29/24, revealed Resident #55 required EBP during high-contact resident care activities due to the presence of an indwelling device. Pertinent interventions included utilizing gowns and gloves during high-contact resident care activities (including device and wound care) and placing EBP notification/signage near the resident's room to alert staff and visitors of the precautions.</p> <p>A review of the August 2024 CPO revealed the following physician's order for EBP:</p> <p>EBP: full PPE with high contact care or activities due to device/wound. Ensure signage is in place, ordered 6/18/24.</p> <p>D. Staff interviews</p> <p>LPN #4 was interviewed on 8/15/24 at 10:49 p.m. LPN #4 said residents with any type of wound or indwelling/invasive line needed EBP. LPN #4 said EBP meant the staff needed to don a gown and gloves before providing care.</p> <p>LPN #4 said nursing staff did not have to follow EBP for feeding tubes, as they were considered a non-sterile exchange.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The infection preventionist (IP) was interviewed on 8/15/24 at 11:15 a.m. The IP said EBP was for residents with indwelling lines and wounds, including feeding tubes. The IP said the need for EBP was identified on admission and the facility also did monthly audits. The IP said a gown and gloves were required when switching lines and changing dressings for residents who were on EBP. The IP said Resident #55 should be on EBP.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 12:25 p.m. The DON said nursing staff should wear a gown, gloves and mask when providing care for residents with indwelling lines, feeding tubes, drains and wounds. The DON said a resident with a feeding tube needed EBP.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>40960</p> <p>Based on record review and interviews, the facility failed to ensure five (#1, #2, #5, #6 and #7) of five certified nurse aides (CNA) received the required 12 hours of annual in-service training for continued competence.</p> <p>Specifically, the facility failed to ensure five CNAs (#1, #2, #5, #6 and #7) received 12 hours of annual training.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The In-Service Nurse Aide Training Program policy and procedure, revised December 2016, was provided by the regional director of clinical services (RDCS) on 8/19/24 at 2:08 p.m. It read in pertinent part, All nurse aide personnel shall participate in regularly scheduled in-service training classes.</p> <p>Annual in-services must:</p> <ul style="list-style-type: none"> -Be no less than 12 hours per employment year; -Address areas of weakness as determined by nurse aide performance reviews; -Address the special needs of the residents as determined by facility staff; -Include training that addresses the care of residents with cognitive impairment; and, -Include training in dementia management and abuse prevention. <p>II. Training review</p> <p>Documentation of annual trainings was requested on 8/14/24 at 1:20 p.m for CNAs #1, #2, #5, #6 and #7.</p> <ul style="list-style-type: none"> -The facility was unable to provide documentation of the 12 hours of required annual training. <p>III. Staff Interviews</p> <p>The nursing home administrator (NHA) was interviewed on 8/15/24 at 11:45 a.m. The NHA said the facility did not have a staff development coordinator (SDC) for a while and recently promoted a floor nurse to be the SDC full time. He said the SDC was responsible for tracking the CNAs annual training. He said the facility used a computer-based program for training for all the facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RDCS was interviewed on 8/15/24 at 11:26 a.m. The RDCS said when the computer-based training program was reviewed, it revealed not all CNAs had not been completing their scheduled training. She said the facility did not have a tracking system in place to track staff training. She said going forward, the facility would review the computer-based training in the middle of every month to ensure all required training was being completed. She said newly hired CNAs training would be reviewed before the CNAs began working with the residents.</p>		