STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	3105 W Arkansas Ave Denver, CO 80219

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 1/27/26 to 1/28/26, resulting in the deficiency being cited as past noncompliance, with a correction date of 12/25/25.I. Facility plan of corrective actionMeasure to address systemic concernsThe facility provided immediate staff education to all nursing staff to:-Document all resident monitoring activities when the resident was on a one to one or line of sight supervision;-Cover units to provide supervision for resident to ensure health and safety of the residents in need, when staff are on break;-Be knowledgeable on identifying types of abuse, reporting requirements and timelines for reporting allegations of abuse; and -Understand the importance and steps to document initial statements form the residents involved and witnesses to gather all possible preinvestigation information to support the facility investigation. Plan to monitor for sustained compliance-The facility chief executive office (CEO)/designee will review all allegations of abuse and the interview packets to ensure that allegations are reported timely, interventions to prevent abuse are followed and care planned and the investigation packet completion was timely; and include detailed interviews, preventative measures, and any education needed. -The CEO/designee will report the findings from the audits or the quality assurance performance improvement committed monthly for 90 days. The QAPI committee was to identify any trend and take corrective actions. II. Facility policy and procedureThe Abuse Reporting and Investigating Policy, dated 2/6/23, was provided by the nursing home administrator (NHA) on 1/28/26 at 8:42 a.m. It revealed in pertinent part, All allegations of abuse or occurrences will be thoroughly investigated. The administrator/designee initiates the investigations.-The administrator/designee provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation.-Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction.-The administrator/designee is responsible for keeping the resident and his/her responsible party informed of the progress of the investigation.-Reviews all events leading up to the alleged incident; and-Documents the investigation completely and thoroughly. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement.-The investigator will record the findings of the investigation and provide the completed documentation to the administrator.III. Allegation of sexual abuse between Resident #5 and Resident #4 on 12/15/25A. Facility investigationThe facility investigation, dated 12/17/25, documented on 12/15/25 at approximately 10:30 p.m., a certified nurse aide (CNA) #1 heard Resident #4 yelling from inside her room. CNA #1 entered Resident #4's room and found Resident #5 standing near Resident #4's bed. CNA #1 immediately intervened and redirected Resident #5 out of the room. Resident #5 was placed on one-to-one supervision. The investigation report documented CNA #1 first said she was not sure if Resident #5 placed his hands on Resident #4 or not. Upon further investigation and follow-up interviews with CNA #1, it was clarified that Resident #5 placed his hands over Resident #4's clothing and bedding in the area of her chest and abdomen. After (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just laying his hands on Resident #4. Additionally, no one was able to explain what the CNA heard the resident yelling about. The corporate nurse consultant said the resident initially denied anything happened. The corporate nurse consultant said when interviewed some of the night staff members thought Resident #5 might have have been going into Resident #4's room to see if she needed help. The corporate nurse consultant said hovering does not mean a lot until the figured out the situation.-However, only one staff observed and reported hearing Resident #4 yelling and non of this was documented in the facility investigation as a part of the investigation. There was no documentation to indicate that this latest assessment of what might have occurred was a part of the investigation or post incident and investigation review. The social services director (SSD) said she reached out to Resident #5's family and they said laying hands on a person in distress was a cultural thing and they did not believe it was inappropriate. The SSD said the resident's son said Resident #5 used to be an energy healer. The NHA said following this incident she implemented the expectation for the night time and weekend charge nurse to start the interview process with the staff and residents involved to gain immediate information that could be forgotten at a later time. The NHA said she also educated staff report alleged incidents to administration immediately and to provide a more detailed description of the incident and what they observed.The NHA said Resident #5 was no longer in the facility and was moved to an all male secured unit.