STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen.Specifically, the facility failed to ensure:-Staff performed hand hygiene was conducted during dishwashing, and, -The food preparation area was clean and sanitary. Findings include: I. Failure to perform hand hygiene during dishwashingA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations (revised 3/16/24), was retrieved on 12/22/25. It revealed in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. ObservationsOn 12/17/25 at 12:49 p.m. dietary aide (DA) #3 was washing the dishes in the dish room utilizing the dishwasher. The clean dish area was full of clean dishes. DA #3 loaded a rack of dirty dishes (with his bare hands). He then went to the clean dish area and began to unload the clean dishes and put them away, without performing hand hygiene. DA #3 then went to the dirty dish side and proceeded to push the rack of dirty dishes into the dishwasher with his bare hands. He then went to the clean dish side and unloaded another rack of clean dishes and put them away without performing any kind of hand hygiene. C. Staff interviewsDA #3 was interviewed on 12/17/25 at 1:58 p.m. He said he would sanitize his hands when going from dirty to clean dishes or he would rinse his hands with the sprayer when going from dirty to clean dishes. The dietary manager (DM) and the nursing home administrator (NHA) were interviewed together on 12/18/25 at 12:35 p.m. The DS said her expectation was for her staff to clean their hands with soap and water before putting away clean dishes. II. Failure to ensure food preparation area was clean and sanitaryA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations (revised 3/16/24), was retrieved on 12/22/25. It revealed in pertinent part, Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: finished to have a smooth, easily cleanable surface. Multiuse food contact surfaces shall be: smooth, free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections, free of sharp internal angles, corners and crevices, finished to have smooth welds and joints. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (Chapter 4)B. Facility policy and procedureThe Kitchen Sanitation policy and procedure, revised November 2022, was provided by the NHA on 12/18/25 at 6:11 p.m. It read in pertinent part, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.C. ObservationsOn 12/17/25 at approximately 2:00 p.m. there was a curved piece of metal that was approximately a foot by two and a half inches on the small food preparation table next to the main steam table and underneath the shelf that held the microwave. Where the metal piece was bent to curve into the depression, there were crumbs that were visible and on each end the metal did not lie flat causing there to be a gap between the metal piece and the table surface. On 12/17/25 at 2:12 p.m. DA #4 pried the piece of metal up with a knife. Once the metal piece was pried up and out of the hole, there were piles of crumbs sitting in the hole and a brown sticky substance was around the edge of the metal piece and the hole. There was also a foul odor coming from the hole. D. Staff interviewsDA #4 and CK #1 were interviewed together on 12/17/25 at 2:12 p.m. DA #4 asked cook (CK) #1 what the metal piece was for. CK #1 said the table used to hold a juice machine and that was where the liquids would drain from. CK #1 said that they switched from that juice machine to a new one years ago and they no longer needed the drainage area. CK #1 said she normally cleaned the area two to three times a day but she had just gotten back from vacation. The DM and the NHA were interviewed together on 12/18/25 at 12:35 p.m. The DM said she was currently working on coming up with a cleaning schedule and she would add cleaning that particular part of the table to the schedule. She said that she would be doing staff training and education regarding cleaning. The NHA said she was not aware of the sticky substance near the table. The registered dietitian (RD) and the DM were interviewed together on 12/18/25 at 1:45 p.m. The DM said the table was used for small types of meal preparation and they would use the table for getting ready to serve the meals. She said it was not used for food preparation. The RD said that they could work it into their budget to get a new preparation table for that area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to remove medications and biologicals that were stored and labeled properly according to professional standards in two of two medication rooms, two of four medication carts and two of four vaccination refrigerators.Specifically, the facility failed to ensure expired medications were removed from the medication room, medication carts, vaccination refrigerator and medication refrigerator. Findings include:I. Professional referencesThe United States Food and Drug Administration (USFDA) Don't Be Tempted to Use ExpiredMedicines (revised 10/31/24), was retrieved on 12/29/25 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth, and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed, there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.II. Facility policy and procedureThe Storage of Medication policy was provided by the nursing home administrator (NHA) on 12/18/25 at 6:11 p.m. It read in pertinent part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or in another secure location. Medications are stored separately from food and are labeled accordingly.III. Observations On 12/16/25 at 12:00 p.m. The first-floor medication room was observed with licensed practical nurse (LPN) #2The medication refrigerator contained the following:-Six Acetaminophen (fever and pain reducer) 650 milligrams (mg) suppositories, which expired in October 2025; and, -Four vials of Prevnar 20 (pneumococcal vaccine) three which expired in January 2025 and the other expired in March 2025.The first floor medication cart B was observed on 12/16/25 at 12:30 p.m. with LPN #2. There were five loose pills observed within the drawers LPN #2 was able to identify.The pills included: -Two Busparone tablets used to treat anxiety disorders;-Two Atrovastin tablets used to lower cholesterol; and, -One Baclofen tablet, used as a muscle relaxant. The second floor medication cart A was observed on 12/16/25 at 1:00 p.m. with LPN #1. There were eight tablets of Mucus Relief DM (expectorant and cough suppressant) which expired in November 2025.There were six unidentified loose pills at the bottom of the drawer. LPN #1 was not able to identify the pills.The second-floor medication room was observed with LPN #1 on 12/16/25 at 11:45 a.m.The following was observed:-Two Hemacolt Developers, a liquid reagent solution used for the fecal occult blood test, expired in January 2025;-Eighty Hemacolt test cards (used for the fecal occult blood test), expired in October 2025;-Two COVID home tests, expired 11/1/24;-Three Assure control solutions (used to check that the meter and the test strips are working properly), expired October 2025, March 2025 and August 2025;-Two open bottles of Vitamin C 500 mg, 200 tablets expired November 2025;-Thirty soft gels of CoQ10 100 mg (an antioxidant), expired August 2025; -Two bottles of Ocular Vitamin, 60 tablets expired November 2025;-Two hundred and fifty tablets of folic acid 400 micrograms (mcg) expired September 2025;-Forty-five Tuberculin syringes with needle expired October 2025; and,-One bottle of eye itch relief expired November 2025.The second-floor medication refrigerator was observed on 12/16/25 at 11:40 a.m. with LPN #1 nurse. There were four Ativan suppositories (used to treat anxiety,) expired 12/14/25IV. Staff interviewsLPN #2 was interviewed on 12/16/25 at 12:25 p.m. LPN #2 said expired medications were to be cleaned out by the nurse manager and the director of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing (DON). LPN #2 said she would take expired medications to the unit manager. LPN #2 said the medication cart was cleaned every shift as the nurses responsibility. LPN #1 was interviewed on 12/16/25 at 1:30 p.m. LPN #1 said that every nurse was responsible for checking the expiration of medications, before giving medications. LPN #1 said the unit manager also checked periodically. LPn #1 said every nurse on their shift was responsible for cleaning the medication cart.The DON and the NHA were interviewed on 12/17/25 at 1:45 p.m. The DON said the nurses and central supply staff were responsible for checking for expired medications. The DON said the risk of giving a medication that was expired was that it could be ineffective. The DON said each nurse on their shift was responsible for cleaning the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of two units.Specifically, the facility failed to:-Ensure housekeeping staff cleaned resident rooms in a hygienic manner;-Ensure housekeeping staff disinfected high-touch areas (call lights, door handles and handrails) when cleaning residents' rooms;-Ensure dwell times were followed during room cleaning;-Ensure staff wore personal protective equipment (PPE) while providing wound care to residents;-Ensure hand sanitizer was not expired;-Ensure staff performed hand hygiene while providing wound care to residents;-Ensure a clean field was created for wound care supplies; and,-Ensure staff performed hand hygiene during meals. Findings include: I. Failure to clean resident rooms in a hygienic manner and disinfect high-touch areas. A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 12/22/25 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 12/22/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. Profect HP Hydrogen Peroxide Disinfectant (2025), was retrieved on 12/29/25 fro: https://www.spartanchemical.com/globalassets/sharepoint/product-literature--documentation---epidocuments/p It revealed in pertinent part One minute contact time ensures efficacy and compliance. Disinfects high touch surfaces in one minute. B. Facility policy and procedure The Cleaning and Disinfecting Resident Rooms policy. revised August 2013, was received from the nursing home administrator (NHA) on 12/18/25 at 6:11p.m. It revealed in pertinent part, the purpose of this procedure is to provide guidelines for cleaning and disinfecting resident rooms. Perform hand hygiene after changing gloves. Change cleaning cloth when they become soiled. Clean horizontal surfaces (bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Clean personal use items (lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly. C. Observations On 12/17/25 at 10:14 a.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER], a double occupancy room. HK#1 performed hand hygiene using an alcohol based hand rub (ABHR) then applied clean gloves. HK #1 took a dry cloth and a spray bottle with hydrogen peroxide disinfectant. She sprayed the dry cloth three times and then began wiping down the door handles to the main door of the resident room. HK #1 then moved the vanity sprayed disinfectant to the cloth again she wiped the counter top then skin handles, then the sink bowel. With the same cloth she cleaned the sink bowl and the soap and paper towels dispensers. -HK #1 failed to use a clean cloth to clean surfaces after wiping down the sink bowl. HK#1 failed to ensure the disinfectant remained wet on the surface for one minute to ensure it was effective in disinfecting the surface. HK #1 returned to her cleaning cart just outside the entry way of the residents' room. HK #1 collected a new cloth, sprayed it with the disinfectant and went to bed B side of the room. She began to wipe down the dresser, night stand, and floor fan. HK #1 moved to bed A side of the room and used the same cloth to wipe down the night stand, dresser and bed side table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HK #1 failed to change the cloth between bed A and bed B sides of the room. HK#1 returned to her cart, collected a new cloth and collected another spray, NABC Concentrate On The Go (broad range germicidal cleaner-disinfectant) and went to the residents' shared bathroom. HK #1 sprayed the NABC cleaner all over the toilet from top to bottom including the riser that was attached to the toilet seat. HK #1 then took a toilet bowl brush stored in the corner of the bathroom behind the toilet and scrubbed the toilet bowl, inner walls of the toilet riser and the bottom of the toilet seat that was propped up in the up position to be kept out of the way from the rise. -HK #1 failed to use only the toilet bowl brush in the bowl of the toilet and failed to clean in a clean to dirtiest manner. She then took the cloth and wiped the toilet from top to bottom. She ran the rag across the floor and the heating unit along the base of the wall in front of the toilet. -HK #1 used the rag she used to clean the toilet to wipe down other areas. HK #1 then returned to her cleaning cart and collected a mop pad from a bucket with multiple pads in it. She wrung the mop pad out allowing excess mop water to fall into the bucket. -HK #1 failed to change her soiled gloves after cleaning the toilet and contaminated her mop water when she reached into it for a mop pad. HK #1 then mopped the bathroom and returned to her cart and reached into the mop bucket a second time with the same gloves. She collected a new mop pad and mopped bed B side of the room. Then HK #1 went to bed A side of the room. HK #1 touched the bedside table with gloves and the fall mat in order to mop the floor on bed A side of the room. HK #1 touched the same items again to put them back in their place after mopping the floor. -HK #1 failed to change her gloves after cleaning the bathroom which then led to her touching surfaces with soiled gloves throughout the resident room. HK #1 contaminated the mop water a second time with soiled gloves touching the mop pads in the bucket. HK #1 returned to her cart and collected another spray bottle and sprayed the room with an odor neutralizer. -HK#1 touched the cart several times throughout observations without changing her gloves. HK #1 returned to her cart, removed her gloves and performed hand hygiene with ABHR. -HK #1 cleaned the entire room with the same gloves. She failed to disinfect the high touch areas in rooms like call lights, bed controls and light switches. D. Staff interviews HK #1 was interviewed on 12/17/25 at 10:21 a.m. HK #1 said areas such as the call light and bed controls were cleaned when a deep clean was done on the room and not on a daily basis. HK #1 said she was not aware she needed to change her gloves at certain times when cleaning a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	double occupancy room or after cleaning the bathroom. She said she did not know she contaminated her mop bucket when she reached in twice to retrieve a mop pad during observations. HK #1 said she was not sure how many cloths' she should have used for cleaning the double occupancy room and she said she did not know she needed to use one cloth for bed A and one for bed B. The environmental service director was interviewed on 12/18/25 at 9:23 a.m. The environmental services director said training for housekeepers was given in a language they understand and he had staff available when he needed something to be communicated to non English speaking staff. The environmental services director said all staff went through two weeks of training where they learned to clean the room in order to ensure they were cleaning high touch areas daily. The environmental services director said high touch areas were to be cleaned daily to prevent the spread of infection. He said high touch areas were call lights, bed controls, handles, bed side tables and light switches. The environmental services director said he did monthly audits of rooms to ensure they were cleaned however he had no documentation to show his audits being completed. The environmental services director said gloves should be changed throughout the cleaning process at certain intervals like moving from bed A to bed B side, after cleaning the bathroom and at any time gloves appear visibly soiled. The environmental service director said the Profect HP disinfectant was effective when the surface remained wet for one minute to ensure it had ample time to properly work. The infection preventionist (IP) was interviewed on 12/18/25 at 11:05 a.m. She said she was to monitor staff for hand hygiene practices and provide education every two weeks or when observed staff needing education. The IP said she worked with the environmental services director to ensure housekeepers were following infection prevention practices like hand hygiene. The IP said her goals were to ensure every one masters hand washing, PPE to help ensure they were informed and prevent infections. II. Enhanced barrier precautions failures A. Professional reference According to the Implementation of personal protective equipment used in nursing homes to prevent the spread of multidrug-resistant Organisms (MDROs) (dated April 2, 2024). Was retrieved on 12/22/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html. It revealed in pertinent part, Enhanced barrier precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, dated August 2022, was received from the NHA on 12/18/25 at 6:11 p.m. It revealed in pertinent part, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:a. Dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. C. Observations On 12/17/25 at 9:35 a.m. wound care was observed for Resident #5. The wound care physician , an unidentified person who came to the facility with the wound care physician and licensed practical nurse (LPN) #4 entered Resident #5 rooms to complete weekly wound rounds. All three entered the resident room and completed the wound care. They completed the wound care without applying all PPE that was required for EBP. The staff applied clean gloves. There was no PPE outside the resident room or inside the resident's room. There was no sign on the resident's door indicating EBP were to be used for Resident #5. At 10:25 a.m. registered nurse (RN) #1 entered resident room [ROOM NUMBER] along with a nurse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practitioner. The resident had a right shin wound and staff were observed to enter the room, apply gloves, remove the old dressing and change gloves The wound care supplies were placed directly on the resident's bed. They cleaned the wound, applied triple antibiotic ointment and covered it with a border dressing.is -The staff failed to wash hands before, during and after wound care. The staff failed to apply PPE while providing wound care and failed to have a clean working area. D. Staff interviews LPN #4 was interviewed on 12/18/25 at 11:05 a.m. she said they did not need to wear PPE when providing wound care as the wound was not draining and there was no risk of splash back. The IP was interviewed on 12/18/25 at 11:05 a.m. She said she was unaware PPE needed to be worn during dressing changes. The IP said staff were informed of EBP during huddles and through reports at shift change. III. Expired hand sanitizer A. Professional reference The Expired hand Sanitizer: Keep or Discard? (Undated) was retrieved on 12/30/25 from: https://ehs.usc.edu/2023/05/12/expired-hand-sanitizers-keep-or-discard/. It revealed in pertinent part, Hand sanitizers are regulated as over-the-counter drugs by the US Food and Drug Administration (FDA) and are required to have an expiration date. Hand sanitizer products past their expiration date are still viable for killing germs on hands; however, their alcohol content may be diminished over time due to evaporation, especially if the container is only partly full, or was stored in a warm place (the interior of a vehicle). B. Observations On 12/16/25 at 12:00 p.m. the first floor medication room was observed with LPN #2. There was one 12 ounce bottle of hand sanitizer that expired March 2023. At 12:30 p.m. the first floor medication cart B was observed with LPN #2. There were two four ounce bottles of hand sanitizer which expired April 2021 and one 18 ounce bottle of hand sanitizer which expired 2022 the month was rubbed off and not legible. C. Staff interviews The IP was interviewed on 12/18/25 at 11:05 a.m. She said ABHR should contain 60 percent (%) alcohol and staff should wash their hands with soap and water after three uses of ABHR. The IP said if ABHR were expired it was not as effective in killing microorganisms. IV. Failure to perform hand hygiene during meals A. Observations On 12/16/25 at 12:08 p.m. Resident #11 was eating with his hands while holding his basketball. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 was holding the basketball with his right hand while eating with his left hand. He was touching the basketball with his left hand prior to the meal starting and hand hygiene was not performed or offered. On 12/16/25 at 12:21 p.m. Resident #11 finished his meal and his drinks. Resident #11 handed his empty cup to an unidentified staff member who was assisting another resident. The staff member took the cup from Resident #11 by grabbing the cup with her thumb on the inside of the cup and the rest of her finger on the outside of the cup. Resident #11 then reached his hand out to her and she then shook his hand using the same hand that she took his used cup from, and shook his hand. She then went back to assisting the other resident with their meal, using the same hand she had used to take the cup and shake Resident #11's hand with, without performing hand hygiene. -The unidentified staff member failed to perform hand hygiene after touching multiple dirty surfaces. During a continuous observation on 12/16/25, beginning at 3:24 p.m. and ending at 5:40 p.m., the following was observed: At 3:24 p.m. Resident #11 was in bed and his basketball was on the floor by the sink in his room. At 4:44 p.m. certified nurse aide (CNA) #1 and CNA #3 went to his room to help get him up. At 4:54 p.m. CNA #3 picked the basketball up off the floor and handed it to Resident #11 without sanitizing the basketball. At 5:05 p.m. the DON sanitized Resident #11's hands and set his basketball on the dining room table. At 5:11 p.m. Resident #11 was holding his basketball again and tapping the ball with his fingers and hand. At 5:22 p.m. Resident #11 was holding an unidentified nurse's hand At 5:23 p.m. Resident #11 handed his basketball to the unidentified nurse and she took it from him, tapped the basketball with her fingers and handed it back to him. The unidentified nurse did not sanitize her hands. She then picked up a spare table setting of silverware from the table and let people know that if they needed another table setting there was one, and she then placed it where it could be used. She then put her hands in her pockets and then cleared some dirty dishes. She did not sanitize her hands. At 5:36 p.m. the unidentified nurse cut Resident #11's food into smaller pieces. She had not sanitized her hands. Resident #11 began eating with his hands and the staff did not sanitize his hands before he began eating. B. Staff interviews LPN #5 was interviewed on 12/18/25 at 1:00 p.m. She said hand hygiene was expected at the start and end of each meal for residents. She said the staff were expected to perform hand hygiene each time they delivered a meal and any time they touched a resident, dirty dishes and in between delivering meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #2 was interviewed on 12/18/25 at 1:58 p.m. She said hand hygiene should be performed before and after meals and any time their hands got soiled. CNA #2 said the staff should be performing hand hygiene all the time. CNA #2 said staff should be performing hand hygiene before touching a resident's meal. CNA #2 said staff could use hand sanitizer five to ten times before washing their hands with soap and water. She said if their hands were soiled then they should wash their hands with soap and water. CNA #2 said if the staff touched Resident #11's basketball they should sanitize their hands before touching any one else's meal. CNA #2 said staff should also sanitize Resident #11's hands and staff should try and sanitize his basketball as much as possible. CNA #3 was interviewed on 12/18/25 at 2:04 p.m. CNA #3 said hand hygiene should be performed after delivering a meal tray to the dishwashing area. CNA #3 said staff should sanitize their hands after touching a resident. CNA #3 said staff should sanitize their hands after touching Resident #11's basketball. CNA #3 said the day shift tried to sanitize Resident #11's basketball at the beginning and end of their shift. The DON was interviewed on 12/18/25 at 4:35 p.m. She said staff should be washing their hands prior to serving and they should hold the plates from the bottom and should not have their thumbs or fingers on the plate. The DON said they should sanitize their hands between plates, but every third plate they should be washing their hands with soap and water. The DON said it was not sanitary for staff to grab a resident's cub by the rim The DON said the staff needed to perform hand hygiene after touching Resident #11's basketball and between tasks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to provide response, action and rationale to residents involved in group grievances. Specifically, the facility failed to effectively address, resolve and demonstrate the facility's response to grievances identified during resident council. Findings include:I. Resident group interviewFour alert and oriented residents (#12, #20, #36 and #71) who regularly attended the resident council meetings were interviewed on 12/18/25 at 11:25 a.m. The residents were identified as alert and oriented through facility and assessment.The group of residents said resident council meetings were not productive and the facility did not follow up on grievances brought up in the resident council meetings or provide resolution.Resident #20 said the residents reported that the staff noise levels on the evening shift woke up residents, but nothing had been done to address it. He said there was a lack of communication from administration as to what is done to resolve the grievances brought up. Resident #12 said if the facility was addressing the grievances, the resolutions were not shared with the resident council or with the resident council president. Resident #12 said the residents on the second floor who did not come to the dining room were served their room trays between an hour and one and a half hours later than the other residents. He said he had reported the concern to staff.II. Record reviewA review of a resident council meeting minutes, dated 9/17/25, revealed group grievances concerning old business from August 2025 of staff coming in on the evening shift being too loud and meals being served late. New business included grievances concerning nurses not being available during meals, having a hard time finding nurses and staff barging into resident rooms without knocking. -There was no documentation that indicated in the meeting minutes that the grievances from August 2025 had been reviewed or resolved. A review of the resident council meeting minutes, dated 10/15/25, revealed group grievances concerning staff coming in on the evening shift were being too loud.-There was no documentation that indicated the resolutions for September 2025 grievances were shared with the resident council. A review of the resident council meeting minutes, dated November 2025, revealed group grievances concerning staff coming in on the evening shift were being too loud.-There was no documentation that indicated the resolutions for October 2025 grievances were shared with the resident council. A review of the grievance forms dated 8/1/25 through 12/1/25 revealed:A grievance form, dated 8/20/25, revealed a resident council concern regarding staff being too loud on the evening shift. The resolution on 9/3/25 was to provide staff education to give reports at shift change in a softer tone or in another area. The grievance had not been documented when resolution was provided or approved by the resident council.A grievance form, dated 9/17/25, revealed a resident council concern regarding that staff were barging into the rooms without knocking. The resolution on 10/6/25 was to provide staff education to knock before entering resident rooms. The grievance had not been documented when resolution was reviewed or provided to the resident council.A grievance form, dated 9/17/25, revealed a resident council concern regarding nursing being more available during medication pass. The resolution on 10/6/25 was to provide staff education to the nurses to assist in the dining room during the evening meals. The grievance had not been documented when resolution was provided to the resident council.-There were no grievance forms regarding late meals provided during the survey (see resident group interview above). III. Staff interviewsThe activities director (AD) was interviewed on 12/17/25 at 2:55 p.m. She said she had just started running the resident council the prior month. The AD said she went over old business and if there was a resolution. She said then the resident council went over any new business. She said when the residents brought up concerns in the resident council, she filled out a grievance form and she brought back a resolution the following month. The AD said that there should be a grievance form for every concern. The NHA was interviewed on 12/17/25 at approximately 3:30 p.m. She said the facility filled out grievance forms for individual grievances and also for group grievances. The NHA said resolutions were provided to the residents during resident council on the resolutions the following month. She said she was unable to provide any of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff education provided that was mentioned on the grievance forms (see record review above). IV. Facility follow upThe NHA provided documentation on 12/17/25 at 4:55 p.m. The documentation indicated staff education regarding knocking on doors, being disruptive at evening shift change and nurses being more available during evening meals was conducted on 12/17/25 (during the survey).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to inform two (#14 and #27) of four residents reviewed for beneficiary notices and appeal rights out of 38 sample residents of changes in their services covered by Medicare in a timely manner.Specifically, the facility failed to provide written notification of a Medicare Non-Coverage letter (NOMNOC) to the resident's representative that Medicare-covered services were ending for Resident #14 and Resident #27 in a timely manner. Findings include:I. Resident #14A. Resident statusResident #14, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) and limitation of activities due to disability.According to the 9/16/25 minimum data set (MDS) assessment, the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident's speech therapy start date was 8/4/25 and did not have a documented end date.B. Record reviewA therapy note, dated 10/7/25, revealed the speech therapist discussed goals with Resident #14 prior to her discharge on [DATE], and the resident agreed with the therapist's goals.The Skilled Nursing facility (SNF) Beneficiary Protection Notification Review revealed the resident's last covered Medicare Part A skilled service was on 10/17/25. The NOMNC was signed by Resident #14 on 10/23/25, which was six days after the resident's Medicare Part A benefits ended. The resident continued to reside in the facility.-However, the facility provided the NOMNC to Resident #14 six days the resident's Medicare Part A services ended, which was not sufficient notification that the current skilled nursing services would likely not be paid for by the Medicare provider and/or health plan and that the resident might have to pay for any services after this date (10/17/25).-Additionally, the untimely issuance of the NOMNC did not provide Resident #14 sufficient time to request for an immediate appeal of the discontinuation of skilled services, which ended on 10/17/25.II. Resident #27A. Resident statusResident #14, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included chronic embolism and thrombosis (blood clots and blood vessel obstructions) of his right lower extremity and dementia.According to the 11/12/25 MDS assessment, the resident had severe cognitive impairment and was unable to complete a BIMS assessment. The assessment documented the resident was receiving physical therapy services.B. Record reviewA progress note, dated 11/13/25 at 2:34 p.m., revealed a therapy staff member called Resident #27's representative and informed her the resident had been discharged from therapy. The resident's representative gave verbal consent for the notice of noncoverage and did not have any questions at the time.The SNF Beneficiary Protection Notification Review revealed the resident's last covered Medicare Part A skilled service was on 11/13/25. The NOMNC was signed by Resident #27's representative on 11/13/25, which was the same day the resident's Medicare Part A benefits ended. The resident continued to reside in the facility.-However, the facility provided the NOMNC to Resident #27's representative the same day the resident's Medicare Part A services ended, which was not sufficient notification that the current skilled nursing services would likely not be paid for by the Medicare provider and/or health plan and that the resident might have to pay for any services after this date (11/23/25).-Additionally, the untimely issuance of the NOMNC did not provide Resident #27's representative sufficient time to request for an immediate appeal of the discontinuation of skilled services, which ended on 11/23/25.III. Staff interviewsThe health information manager (HIM) and director of rehabilitation (DOR) were interviewed together on 12/18/25 at 10:24 a.m. The HIM said when the therapy team told her a resident had reached their end of therapy and then the HIM or the therapy team filled out the resident's NOMNOC/ABN. The HIM said she checked to see if the resident has a responsible party, notified the responsible party and got their signature before uploading the NOMNOC into the resident's chart. The HIM said she issued the NOMNOC and ABN four days prior to their discharge from therapy.The HIM said Resident #27's therapy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services ended 11/13/25.The DOR said Resident #27's discharge date from therapy was 11/13/25. The DOR said she missed the date for issuing Resident #27's NOMNOC. The DOR said the therapy team had talked to Resident #27's representative and she was aware of the resident's progress and that his time in therapy was winding down. The DOR said they had realized the therapy team had not done their non-coverage notice. The DOR said she had assumed the role of director earlier that month and was new to the position, and was not yet tracking non-coverage as part of her role.The HIM said Resident #14's NOMNOC was issued on 10/23/25. The DOR said they did not have a rehabilitation director at the time who tracked services/noncoverage, so the therapy team was trying to catch up on their notices. The DOR said the therapy team had talked with Resident #14 and she was aware her services were winding down. The DOR said Resident #14's therapy services ended on 10/17/25. The DOR said the therapy team had discussed Resident #14's goals and upcoming discharge on [DATE] during their session on 10/7/25.-However, the facility did not provide a written NOMNOC to Resident #14 until 10/25/25, six days after the resident's services were discontinuedThe nursing home administrator (NHA) was interviewed on 12/18/25 at 3:01 p.m. The NHA said the NOMNOC was issued three days prior to the resident's end of services and was sent to the resident or their responsible party to be signed. The NHA said the NOMNOC was sent out three days prior to the end of service date so the resident or their representative could appeal the decision if they did not want to lose services. The NHA said the HIM issued the NOMNOCs.The NHA said there were notes prior to Resident #14's discharge from services which documented the resident was aware she was being discharged from therapy, and the resident had not mentioned wanting to extend her services.The NHA said the former DOR had left the faciity on leave and later resigned from her position. The NHA said the current DOR worked at another facility during that time and came to the facility to help with staff coverage. The NHA said if there were any NOMNOCs that were issued late, it was due to the lapse in DOR position coverage. The NHA said she would do education for the staff and be more involved in the non-coverage process moving forward.-However, the facility did not provide a written NOMNOC to Resident #14 until 10/25/25, six days after the resident's services were discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#24) of five residents were free from chemical restraints and were receiving the least restrictive approach for their needs out of 34 sample residents. Specifically, the facility failed to ensure evidence was present that indicated Resident #24 had an increase in behaviors that warranted an increase in antipsychotic medication increases. Findings include:I. Facility policy and procedureThe Psychopharmological policy, undated, was provided by the nursing home administrator (NHA) on 12/18/25 at 6:11 p.m. It revealed in pertinent part,The primary physician, psychiatrist (if applicable) and/or consultant pharmacist will monitor residents who are prescribed psychopharmacological drugs at least quarterly to assure these drugs are utilized according to State and Federal regulations and for the appropriate treatment of resident diagnosis.The interdisciplinary team which may consist of, but is not limited to, Nurse Managers, Social Services, dietary manager, activity professional, CNA (certified nurse aide), and mental health professional/case manager will review residents on psychopharmacological drugs at least quarterly. This meeting will include a review of the following: behavior tracking and psychiatrist (if applicable) /mental health clinician notes.II. Resident #24A. Resident statusResident #24 age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included anxiety, major depressive disorder and unspecified dementia. The 12/12/25 minimum data set (MDS) assessment revealed Resident #24 had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. The MDS assessment indicated the resident had demonstrated behaviors of delusions, verbal aggression and wandering. B. Resident interviewResident #24 was interviewed on 12/16/25 at 2:17 p.m. Resident #24 was unable to determine the day of the week, the year or what type of facility he was living in. He said he was not taking any psychiatric medications and could not identify any of his medications. C. Record reviewThe antidepressant medication care plan, revised 7/29/25, revealed Resident #24 used antidepressant medications related to signs and symptoms of depression. Interventions included monitoring behaviors of wandering/exit seeking, verbal aggression, paranoia, disruptive/intrusive, and disorganized thinking (revised 3/24/25), providing education to the resident, family, and caregivers about risks, benefits and the side effects and/or toxic symptoms (revised 5/16/23) and monitoring for hallucinations/delusions, social isolation, suicidal thoughts, decline in activity of daily living abilities, and insomnia (initiated 7/22/2020). -The antidepressant medication care plan did not include the physician's indication for use (hypersexual behaviors).The antipsychotic medication care plan, revised 7/29/25, revealed Resident #24 used antipsychotic medications related to symptoms and behaviors related to dementia. Interventions included monitoring behaviors of hallucinations/expressing delusions, verbal/physical aggression, and hypersexualized comments (revised 3/24/25), reviewing behaviors/interventions and alternate therapies attempted and their effectiveness (initiated 7/22/2020) and utilizing non-pharmacological interventions such as cold therapy, range of motion therapy, massage, relaxation/breathing techniques, imagery and distraction techniques, aromatherapy, and therapeutic touch (initiated 7/22/2020). -The antipsychotic medication care plan did not include revisions related to the 8/18/25 or the 10/22/25 medication increases revealing an increase in behaviors or a worsening of the resident's condition. Review of Resident #24's December 2025 CPO revealed the following physician's orders:Sertraline (an antidepressant medication) 100 milligram (mg) one time a day for hypersexual behaviors, ordered on 5/21/25.Olanzapine (an antipsychotic medication) 5 mg. Give one time a day for dementia with agitation, ordered 5/21/25 and increased 8/18/25.Olanzapine 5 mg. Give two tablets (total of 10 mg) one time a day for dementia with agitation, ordered 8/18/25 and increased 10/22/25. Olanzapine 20 mg. Give one time a day for dementia, ordered 10/22/25.Monitor behaviors related to dementia: 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hallucinations/expressing delusions. 2. Verbal/physical aggression. 3. Hypersexualized comments. Non-pharmological interventions included: A. Redirection. B. One-on-one. C. Activity. D. Low stimulation environment. E. Offer toileting. F. Offer a snack. G. Offer fluids. H. Assess for pain. I. Other- document in progress notes, ordered on 8/17/25.-The dementia behavior monitoring order did not include revisions to reflect an increase in behaviors or a worsening of the resident's condition related to the increase of the resident's antipsychotic medication on 10/22/25. Monitor behaviors related to major depressive disorder: 1. Wandering/exit seeking. 2. Verbal aggression. 3. Paranoia 4. Disruptive/intrusive. 5. Disorganized thinking. Non-pharmological interventions included: A. Redirection. B. One-on-one. C. Diversional activity. D. Offer to call family or friend. E. Other-document in progress notes. F. Offer a walk, candy, soda, or snack of choice, ordered on 10/13/25.Review of Resident #24's EMR from 8/1/25 to 12/16/25 revealed the following:A guardianship referral, dated 3/24/24, revealed the facility had sent a referral to a guardianship agency for Resident #24 due to the resident being unable to make his own decisions related to diminished cognition. The pharmacist's monthly medication review, dated 6/14/25, revealed a recommendation to decrease Resident #24's olanzapine. The physician made a note at the bottom of the review that they neither agreed or disagreed but that there needed to be a review of history and behaviors with the nurse.A psychiatrist visit note, dated 7/7/25, revealed that the resident was assessed for safety and deemed his current risk to be low and was at his psychiatric baseline. The psychiatrist included their observation of the resident as calm and agreeable and during the interaction with the psychiatrist, Resident #24 was pleasant and cooperative. No hallucinations or delusions were reported or observed. The pharmacist's monthly medication review, dated 7/10/25, revealed a recommendation to decrease Resident #24's olanzapine. The physician made a note at the bottom of the review that they neither agreed or disagreed but that the physician deferred the decision to the psych team managing. A psychiatrist visit note, dated 7/21/25, revealed the resident was psychiatrically stable and at his baseline with no acute mood or behavioral concerns. The psychiatrist included their observation of the resident as calm and agreeable and during the interaction with the psychiatrist, with no new or ongoing symptoms of anxiety, depression, psychosis or other psychiatric disturbances. The resident also remained socially appropriate and cooperative during interactions with others. No hallucinations, paranoia or delusions were reported or observed. A psychiatrist visit note, dated 8/5/25, revealed the resident was assessed for safety and deemed his current risk to be low and was at his psychiatric baseline. The note indicated the resident was calm and agreeable. During the interaction with the psychiatrist, Resident #24 was pleasant and cooperative. No hallucinations or delusions were reported or observed. A psychiatrist visit note, dated 8/19/25, revealed the psychiatrist documented the staff had not reported any recent behavioral changes or psychiatric concerns. The note documented Resident #24 had been stable in mood, sleep and appetite patterns. The note documented the resident was calm, cooperative and in no acute distress. The resident engaged appropriately with the clinician and responded clearly to direct questions, with no signs of psychosis, mania, agitation or hallucinations.Review of the interdisciplinary team (IDT) psychotropic pharmacological meeting notes, dated 8/19/25, revealed there were no recommendations made to Resident #24's medication regimen and no explanation for the increase of the olanzapine on 8/18/25. A nursing note, dated 8/20/25, revealed the resident used derogatory racial slurs towards staff and the staff redirected the resident.A nursing note, dated 8/21/25, revealed the resident's physical condition had declined and the resident had to be sent out to the hospital. A psychiatrist visit note, dated 9/2/25, revealed the resident was assessed for safety and deemed his current risk to be low and was at his psychiatric baseline. The resident was calm and agreeable. During the interaction with the psychiatrist Resident #24 was pleasant and cooperative.A psychiatrist visit note, dated 9/16/25, revealed the resident was psychiatrically stable and at his baseline. The resident was calm and agreeable. Resident #24 was pleasant and cooperative. The concluded findings were the resident presented without mood or behavioral disturbances or safety concerns.-Psychiatrist visit notes dated 6/14/25 and 9/16/25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failed to reveal documentation the pharmacist was made aware of the rationale for not conducting a reduction. The visit notes from 7/7/25 to 9/16/25 also failed to mention increasing the resident's olanzapine and instead documented the resident was stable and had no psychiatric changes necessitating increases to his antipsychotic usage.-Review of the resident's EMR revealed there were no documented psychiatrist visits after 9/16/25. The pharmacist's monthly medication review, dated 10/4/25, revealed the following note from the pharmacist: CMS recommended max doses for dementia with behaviors diagnosis of olanzapine is 5mg. The resident is currently taking 10 mg daily. Consider a gradual dose reduction (GDR) for olanzapine with a target dose of 5 mg or adjust to an appropriate diagnosis. The physician made a note at the bottom that they declined the recommendation due to staff and nurse practitioners noting Resident #24's behaviors continue and pose a significant risk to others. A behavior note, dated 10/8/25, revealed the resident punched the wall with his hand and the staff redirected him. A behavior note, dated 10/22/25, revealed the resident was verbally aggressive towards another resident and the staff redirected him.The IDT psychotropic pharmacological meeting notes, dated 11/12/25, revealed there were no recommendations made to Resident #24's medication regime and no explanation for the increase of the olanzapine on 10/22/25.A review of the nurse behavior monitoring on the treatment administration records (TAR) from 8/1/25 to 12/16/25 revealed no documented behaviors.A review of certified nurse aide (CNA) behavior notes from 8/1/25 to 12/16/25 revealed the following: On 10/4/25 the resident displayed behaviors not directed at others of refusing care. Interventions attempted were redirection and offering snacks/fluids. The behavior note did not indicate which, if any, interventions were effective. On 10/11/25 the resident displayed behaviors not directed at others of refusing care and self neglect. Interventions attempted were redirection, offering snacks/fluids, and engaging in conversation. The behavior note did not indicate which, if any, interventions were effective. On 11/8/25 the resident displayed behaviors not directed at others of refusing care. Interventions attempted were redirection, ADL care, engaging in conversation and offering a calm environment. The behavior note did not indicate which, if any, interventions were effective. -CNA behavior notes did not reveal there was an increase in the resident's behaviors that warranted an increase of the antipsychotic medication Informed consent for psychoactive medication use, dated 8/18/25, listed an increase of olanzapine 5 mg once a day but did not document that the medication was being increased to twice a day to equal 10 mg a day.Informed consent for psychoactive medication use, dated 10/24/25, listed an increase of olanzapine to 20 mg a day. III. Staff interviewsCNA #4 was interviewed on 12/17/25 at 9:30 a.m. CNA #4 said Resident #24 had behaviors of yelling at people if someone came too close to him or to his belongings. She said the resident was generally very agreeable and kind towards staff and she could not recall the last time she had observed any aggressive behaviors with Resident #24. Registered nurse (RN) #1 was interviewed on 12/17/25 at 9:41 a.m. RN #1 said the nurses were to look at the resident's care plan for target behaviors and resident specific non-pharmological interventions. RN#1 said what typically happened is that the nurses would call social services to come and intervene when the resident was having a behavior. She said nurses were expected to document resident behaviors in a progress note and the MAR. RN #1 said Resident #24 had behaviors of yelling at people, becoming frustrated when he could not remember where his room was, and making racist statements. She said he did not have behaviors of physical aggression, hallucinations, or delusions. Licensed practical nurse (LPN) #7 was interviewed on 12/17/25 at 10:11 a.m. LPN #7 said the nurses looked at the behavior monitoring in the CPO for behaviors and interventions and documented them in the TAR. She said Resident #24 did not have any aggressive verbal or physical behaviors. The NHA and the social services director (SSD) were interviewed on 12/18/25 at approximately 12:30 p.m. The NHA said the facility's process for ensuring the efficacy of psychoactive medications was to consult through the behavioral health provider and the psychiatrist on appropriate behaviors and interventions. She said the director of nursing (DON) and the SSD worked together to manage the behavior monitoring through monthly review. The NHA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the SSD established the timeframes for when residents were to be reviewed in the psychotropic drug meeting. The NHA said during the psychotropic drug meeting, the IDT reviewed the behavior documentation completed by the CNAs and nurses. She said nurses documented behaviors in the TAR and made a behavior progress note by exception. The NHA said the CNAs documented in their own charting system. The NHA said the CNA charting did not allow for the CNAs to customize the behaviors or the interventions, it only provided a generic template that was the same for all the residents. She said the IDT reviewed the number of behaviors documented throughout the month but if there was a behavior displayed that was not on the generic template, the CNAs had to verbally tell the nurse. The NHA said the IDT utilized nurse and CNA behavior monitoring to track the effectiveness and necessity of the psychoactive mediations by showing increases, decreases or stability in behaviors. The SSD said after she received the visit notes from the psychiatric team, she reviewed the notes for any recommendations and relevant changes to the resident's condition. She said she was unable to say why the psychiatrist notes did not indicate antipsychotic medication increases for Resident #24. The NHA said psychotropic consents were obtained from the resident or responsible party before the medication was administered. She said Resident #24 was showing an increase in behaviors and verbal threats to others and the behavior increases were discussed and documented in the IDT psychotropic pharmacological meeting notes. She said she was unable to locate the notes for the behavior increases and discussion for the necessity of increasing the olanzapine. The NHA said she would locate the documentation of behaviors to justify the increases to the olanzapine for Resident #24. -However, documentation was not provided that provided a justification for the increases in medication. The NHA said she was unable to explain why Resident #24 was taking an antidepressant for hypersexual behaviors and said she would have to look into this. The NHA said regarding pharmacist's recommendations, the NHA satisfied her obligation to ensure the recommendations were given to the physician to review. She said that was her only responsibility, not to ensure there was documentation of the recommendations being acted upon. V. Facility follow-upAn email was received by the NHA on 12/18/25 at 4:20 p.m. It contained the following explanation for Resident #24's Sertraline diagnosis of hypersexual behaviors:It was identified upon review of documentation that we had the incorrect diagnosis of Sertraline, the provider came in and changed the order to hypersexualized behaviors, however the diagnosis should have remained depression.The NHA was interviewed again on 12/18/25 at approximately 5:00 p.m. The NHA said the facility had not noticed that the Sertraline diagnosis had been changed to hypersexual behaviors on 5/21/25 until brought to their attention during the survey. She said this had been reviewed by the IDT psychotropic pharmacological meeting team, the psychiatrist and the pharmacist nine times between 6/14/25 and 10/4/25. On 12/18/25 at 6:10 p.m. the NHA forwarded an email from the psychiatrist, dated 12/18/25 (during survey). The psychiatrist revealed in the email that the GDR recommendations made by the pharmacist on 6/14/25 and again on 7/10/25 for the olanzapine were discussed between her and the nurse practitioner (NP) for Resident #24. The psychiatrist said the two agreed that a GDR would be too soon after the last GDR in May 2025 from 7.5 mg to 5 mg. -However, review of Resident #24's EMR did not reveal documentation regarding the conversation between the psychiatrist and the NP. -The facility failed to provide documentation indicating the resident had increased behaviors from his baseline that warranted an increase in psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) Level II determination and evaluation from the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#39) of two residents reviewed for PASRR out of 38 sample residents.Specifically, the facility failed to arrange and incorporate recommendations from the PASRR Level II notice of determination (NOD) for Resident #39. Findings include:I. Facility policy and procedureThe PASRR policy, dated 9/26/23, was provided by the nursing home administrator (NHA) on 12/18/25 at 6:11 p.m. It revealed in pertinent part,The social service staff are responsible for assuring that the specialized services needed or recommended by the PASRR- Level II are reviewed, implemented, and care planned within the facility within 14 days of admission. There should be a valid and detailed written explanation in cases when the PASRR -Level II recommendations cannot be implemented. If services recommended cannot be provided, then the facility is responsible for transferring/discharging the individual to a placement where such services are available.II. Resident #39A. Resident statusResident #39, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included borderline personality disorder and major depressive disorder. The 11/5/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment indicated the resident had behaviors of delusions.The assessment did not identify that the resident had been identified as having a Level II PASRR. B. Record reviewResident #39's PASRR Level II, provided to the facility on 8/6/24, included the evaluation which revealed the resident had been evaluated for mental illness due to a qualifying diagnosis of major depressive disorder. The resident was to receive a neurocognitive evaluation (an assessment to determine how different parts of the brain function to understand the impact of neurological conditions and brain injuries).Resident #39's mood and behavior care plan, revised 3/4/24, revealed the resident had a Level II PASRR due to a diagnosis of major depressive disorder and borderline personality disorder. Interventions, initiated dated 8/7/23, included psychiatric care services, offering one-on-one conversation and reviewing her medications quarterly. -The care plan failed to include the PASRR Level II recommendation for Resident #40 to have a neurocognitive evaluation (see PASRR Level II above). Review of the December 2025 CPO failed to reveal any orders for a neurocognitive evaluation since the resident's NOD date of 8/6/24. Progress notes were reviewed from 8/1/25 through 12/16/25 and documentation was found regarding the Level II PASRR or recommendations for Resident #40. There were no PASRR progress notes revealing communication with the State Mental Health Agency regarding a delay or inability to follow Resident #40's PASRR Level II recommendations.III. Staff interviewsThe social services director (SSD) and the NHA were interviewed together on 12/18/25 at approximately 12:30 p.m. The SSD said the social services department was responsible for managing and reviewing the recommendations made by the State Mental Health Agency included in the PASRR Level II. The NHA said if the recommendations from the NOD were not followed, then a progress note would be made and it would also be included in the resident's care plan. The NHA said she would have to look into if a neurocognitive evaluation was ever scheduled for Resident #39. -However, documentation was not provided during the survey that indicated Resident #39 received a neurocognitive evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#24) of five residents received medically related social services out of 38 sample residents. Specifically, the facility failed to:-Assist Resident #24 with obtaining a designated representative who could assist the resident with making choices; and,; -Ensure Resident #24 had the ability to give informed consent to psychoactive medications. Findings include:I. Resident #24A. Resident statusResident #24, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included anxiety, major depressive disorder and unspecified dementia. The 12/12/25 minimum data set (MDS) assessment revealed Resident #24 had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. The MDS assessment indicated the resident had a wander guard device but no other forms of restraints. B. Resident interviewResident #24 was interviewed on 12/16/25 at 2:17 p.m. Resident #24 was unable to determine the day of the week, the year, or what type of facility he was living in. He said he was not taking any psychiatric medications and could not identify any of his medications. Resident #24 said he had never consented to the transfer pole in his room and could not explain the risks of a transfer pole. C. Record reviewThe cognition care plan, revised 7/29/25, revealed Resident #24 used antipsychotic medications related to symptoms and behaviors of dementia with behaviors. Interventions included discussing with the medical director, power of attorney or family the ongoing need for medication and alternate therapies attempted (initiated 7/22/20). -The care plan failed to include documentation regarding the transfer pole or cognitive impairments requiring a guardian referral (see progress notes below). Review of Resident #24's December 2025 CPO revealed the following physician's orders:Olanzapine (an antipsychotic medication) 5 milligram (mg). Give one time a day for dementia with agitation, ordered 5/21/25 and increased 8/18/25.Sertraline (an antidepressant medication) 100 mg one time a day for hypersexual behaviors, ordered on 5/21/25.Olanzapine 5 mg. Give two tablets one time a day for dementia with agitation, ordered 8/18/25 and increased 10/22/25. Olanzapine 20 mg. Give one time a day for dementia, ordered 10/22/25.Review of Resident #24's electronic medical record (EMR) from 3/24/24 to 12/16/25 revealed the following:A guardianship referral, dated 3/24/24, revealed the facility had sent a referral to a guardianship agency for Resident #24 due to the resident being unable to make his own decision related to diminished cognition. -However, review of Resident #24's EMR did not reveal documentation indicating the referral had been followed up on.A nurse practitioner visit note, dated 4/22/24, revealed the nurse practitioner documented that Resident #24 had impairments to the quality of his speech and language, short term memory impairments, poor judgement, and poor insight. The IDT psychopharmacology meeting note, dated 11/12/25, revealed Resident #24 needed a guardian.A social services note, dated 12/16/25 (during survey), revealed the social services director (SSD) had sent an email to a guardianship agency. The psychiatrist visit notes dated 8/19/25 to 12/16/25 revealed the following;A visit note, dated 8/19/25, indicated Resident #24 was unable to participate in the assessment in a meaningful way due to cognitive deficits. The resident was oriented to self and disoriented to time and place. A visit note, dated 9/16/25, revealed the resident presented with severe cognitive deficits present in one or more areas of memory and thought production during the visit.Review of Resident #24's treatment consents from 1/1/25 to 12/16/25 revealed the following:Informed consent for physical restraint/assistive device for the transfer pole, dated 1/6/25, did not reveal the resident or any representative had given consent, or had been informed of the potential negative outcomes, the risks, and the benefits.Informed consent for physical restraint/assistive device for the transfer pole, dated 4/28/25, did not reveal the resident or any representative had given consent, or had been informed of the potential negative outcomes, the risks and the benefits.Informed consent for psychoactive medication use, dated 8/18/25, revealed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident signed the consent himself and the consent listed an increase of Olanzapine 5 mg once a day but did not document that the medication was being increased to twice a day to equal 10 mg a day.Informed consent for psychoactive medication use, dated 10/24/25, revealed the resident signed the consent himself and the consent listed an increase of Olanzapine to 20 mg a day. -However, the resident was not aware he was on psychotropic medications and had severe cognitive impairments. -A review of Resident #24's EMR failed to reveal an appointed resident representative to assist on the resident's behalf in making care decisions. II. Staff interviewsCNA #4 was interviewed on 12/17/25 at 9:30 a.m. She said Resident #24 had behaviors of yelling at people if they came too close to him or his belongings related to his dementia and not understanding other's intentions. Registered nurse (RN) #1 was interviewed on 12/17/25 at 9:41 a.m. She said Resident #24 was only oriented to himself and some people. She said he was unable to make his own decisions or sign consents for himself and he had no friends or family members to make decisions on his behalf. She said the medical director (MD) made all the decisions for Resident #24 because the resident could not make his own decisions. Licensed practical nurse (LPN) #7 was interviewed on 12/17/25 at 10:11 a.m. She said Resident #24 could express his basic needs to the staff but did not know what medications he took. The social services director (SSD) was interviewed on 12/18/25 at 9:45 a.m. She said that it was the social services departments' job to initiate guardianship referrals and follow up on making sure a physician letter was obtained and sent to the guardianship agency. The SSD said she had only worked at the facility for three months but was not sure why no one else had followed up on the referral or why she did not follow up on the referral herself until the survey. The NHA was interviewed on 12/18/25 at approximately 12:30 p.m. The NHA said she was not sure why the guardian referral for Resident #24 was not followed up on. III. Facility follow upOn 12/18/25 at 6:21 p.m., the NHA forwarded an email from the guardianship agency dated 12/18/25.The email confirmed the agency would schedule an assessment within two weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were provided adequate hydration for one (#11) of two residents reviewed for hydration out of 38 sample residents. Specifically, the facility failed to provide drinks during meal time and provide fluids throughout the day for Resident #11. Findings include: I. Facility policy and procedureThe Hydration policy, dated 2/29/24, was received from the nursing home administrator (NHA) on 12/18/25 at 6:11 p.m. It read in pertinent part, Residents are provided with sufficient fluid intake to maintain proper hydration and health. Residents identified at risk for fluid volume deficit will be assessed timely and provided appropriate interventions to promote adequate hydration. Address resident's individual needs with respect to fluid intake. Initiate appropriate strategies and interventions to prevent dehydration.II. Resident #11A. Resident statusResident #11, age [AGE], was admitted to the facility on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included epilepsy (seizure disorder), hypothyroidism, hyperlipidemia and unspecified intellectual disabilities. The 10/31/25 minimum data set (MDS) assessment revealed Resident #11 was rarely or never understood. Through staff assessment, it was revealed Resident #11had severe cognitive impairment. The MDS assessment further revealed Resident was dependent on staff for all of his activities of daily living (ADL). B. Resident representative interviewResident #11's resident representative was interviewed on 12/16/25 at 10:38 a.m. She said she never saw drinks in his room or at his bedside. C. ObservationsDuring a continuous observation on 12/16/25, beginning at 3:24 p.m. and ending at 6:04 p.m., the following was observed:At 3:24 p.m. Resident #11 was in his bed with his eyes closed. There was no water or other beverages in his room at his bedside. At 3:28 p.m. Resident #11 was sitting up in his bed leaning against the wall with his legs tucked underneath him. At 3:55 p.m. Resident #11 was sitting up in his bed. No staff members had entered his room to offer him a beverage. At 4:44 p.m. o certified nurse aide (CNA) #1 and and CNA #3 entered Resident #11's room to assist him up for dinner. At 5:05 p.m. Resident #11 was in the dining room sitting at his table. He did not have any drinks. At 5:36 p.m. Resident #11 received his dinner, but did not have any drinks. At 5:40 p.m. Resident #11 was eating his finger foods and staff did not offer him or provide any drinks. At 5:47 p.m. Resident #11 handed his plate to an unidentified nurse, she took his plate from him and did not offer him any drinks. Resident #11 was not provided with any drinks. At 6:04 p.m. CNA #1 assisted Resident #11 to his room. -He did not receive any drinks at dinner and there were no beverages in his room. D. Record reviewThe skin integrity care plan, revised 9/15/25, documented Resident #11 was at risk for skin integrity issues because he had soft, friable skin and was dependent on staff for personal care and mobility. Interventions included encouraging good nutrition and hydration in order to promote healthier skin. The malnutrition care plan, revised 7/29/25, documented Resident #11 was low to moderate risk for malnutrition due to poor intake. Interventions included encouraging Resident #11 to eat food and drink fluids. E. Staff interviewsCNA #1 was interviewed on 12/18/25 at 9:08 a.m. She said the staff usually gave Resident #11 orange juice to drink and they put milk in his cream of wheat. She said the resident was on a regular diet with thin liquids. She said most residents were able to walk around and get their own ice and drinks from the nurse's station or the coffee area in the dining room. She said the CNAs would fill residents' water jugs if they ask. She said they offered water at the dining room table during meals and the staff offered water to the residents every two hours. -However, Resident #11 was not offered drinks (see observations above)Licensed practical nurse (LPN) #6 was interviewed on 12/18/25 at 9:28 a.m. She said Resident #11 consumed fluids well at the dining room table. She said Resident #11 had drinks at his bedside. -However, Resident #11 did not have drinks at his bedside (see observations above).The registered dietician (RD) and the regional dietary consultant were interviewed together on 12/18/25 at 1:15 p.m. They said every resident should receive at least (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065323	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denver North Care Center	2201 N Downing St Denver, CO 80205

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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eight ounces of liquid at every meal. The regional dietary consultant said that some of the residents did not have the water jugs in their room as the had used them as a weapon. The regional dietary consultant said most of the residents received their fluids during meal time or activities. She said fluids should be offered frequently. They said residents should be given drinks with their meals. CNA #3 was interviewed on 12/18/25 at 2:04 p.m. He said he delivered drinks with room trays, and he offered drinks as the residents came in from smoke breaks. He said Resident #11 was up in his chair most of the day. CNA #3 said Resident #11 could not drink when he was in bed unless the staff sat him up. He said the staff tried to get him to drink when he was up in his chair. He said the staff offered him fluids when he was in bed and each time they checked on him for incontinence care -However, CNA #3 did not offer Resident #11 a drink when he checked on him (see observations above). The director of nursing (DON) and the NHA were interviewed together on 12/18/25 at 4:35 p.m. The NHA said any staff member could offer fluids to residents. The DON said staff should be offering fluids during meals and outside of meals. The DON said the risks for residents if they did not get enough fluids are urinary tract infections, dehydration, skin issues and elevated temperature. The DON said the staff needed to be better with rounding with fluids on dependent residents.