STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065344	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Clermont Park Care Center, The	2480 S Clermont St Denver, CO 80222

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure one (#38) of two residents reviewed for resident rights out of 35 sample residents received appropriate treatment and services consistent with his interests, assessments and plan of care. Specifically, the facility failed to ensure Resident #38 received his showers consistently with his preferences. Findings include: I. Resident #38A. Resident status Resident #38, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized orders (CPO), diagnoses included acute respiratory failure with hypoxia (low blood oxygen levels), urinary tract infection and muscle weakness. The 2/4/26 minimum data (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The resident required moderate assistance for showering and was dependent on staff for toileting, dressing, eating, hygiene and transfers. B. Resident representative interview Resident #38's representative was interviewed on 2/16/26 at 1:50 p.m She said they were told Resident #38 would be getting showers twice a week on Wednesdays and Saturdays. She said Resident #38 had missed showers on two Saturdays in a row. She said she was concerned about him missing showers. She said she was told it was because Resident #38 required two people to assist him in the shower and they did not have enough staff on those days. C. Record review Resident #38's care plan, initiated 1/30/26, documented the resident needed substantial or maximal assistance for bathing or showering. The bathing task record documented Resident #38 preferred to be bathed on Wednesdays and Saturdays in the evening. The bathing task record from 1/30/26 to 2/15/26 documented Resident #38 received showers for three out of five opportunities. D. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 2/17/26 at 1:10 p.m. She said Resident #38 required two people to assist with activities of daily living (ADL) including transferring and showering. She said he did not refuse care. She said he preferred his showers in the evening. She said if a resident refused a shower, she would let the nurse know. Licensed practical nurse (LPN) #1 was interviewed on 2/18/26 at 11:37 a.m. She said Resident #38 could be combative with staff during cares at times. LPN #1 said when he had these behaviors, she would expect staff to step away and attempt to reapproach. She said the resident should be getting their showers twice a week and she was not aware of Resident #38 missing any showers. She said if a resident did miss a shower, she would expect staff to attempt later that shift or the next day. She said she would document a nursing progress note if she was informed about a resident missing their shower. The director of nursing (DON) was interviewed on 2/18/26 at 12:05 p.m. She said staff were expected to offer showers twice weekly to all residents. She said the nursing staff scheduled showers for the new residents initially and would adjust the showers days or times as needed while they get to know the resident preferences. The DON said if a resident missed a shower, she would expect staff to encourage the shower and reapproach later. She said she would expect the staff offering the shower to communicate it with the nurse when the resident missed a shower. The DON said she would expect the nurses to document a progress note if they had been notified of a resident missing a shower. The DON said she had recently learned about Resident #38 having behaviors and she would expect staff to document those behaviors.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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.Specifically, the facility failed to rinse and store nebulizers (a small machine that turns liquid medication into a mist that can be inhaled to treat lung conditions) masks and reservoirs properly. Findings includeI. Professional referenceThe Center for Disease (CDC) Guidelines for the Prevention of Nosocomial Pneumonia, dated September 2024, was retrieved on 2/19/26 from https://www.cdc.gov/mmwr/preview/mmwrhtml/00045365.htm. It read in pertinent part: Outbreaks related to the use of respiratory-therapy equipment have been associated with contaminated nebulizers. When the fluid in the reservoir of a nebulizer becomes contaminated with bacteria, the aerosol produced may contain high concentrations of bacteria that can be deposited deep in the patient's lower respiratory tract. Contaminated reservoirs of aerosol-producing devices (nebulizers) can allow the growth of hydrophilic bacteria that subsequently can be aerosolized during use of the device and can multiply to substantial concentrations in nebulizer fluid and increase the risk for pneumonia in patients using such devices. Small-volume medication nebulizers and hand-held nebulizers should be disinfected, rinsed with water and air dried.II. ObservationsOn 2/16/26 at 2:34 p.m. Resident #27's nebulizer reservoir was attached to the mask in the top drawer of the night stand. The drawer included multiple papers, chapstick and creams. On 2/17/26 at 11:58 a.m. Resident #27's nebulizer reservoir was attached to the mask in the top drawer of the night stand. The drawer included a used tube of antifungal cream, a box of gloves, letters, papers and chapstick.On 2/18/26 at 10:20 a.m. Resident #27's reservoir was attached to the mask in the top drawer of the night stand. The drawer included a used tube of antifungal cream, a bottle of foam rinse cleaner, a box of gloves, a package of opened wet wipes, multiple papers and chapstick. III. Resident interviewResident #27 was interviewed on 2/18/26 at 10:25 a.m. She said she did not know when her nebulizer mask and reservoir had been cleaned. She said it was always stored in the top drawer of her night stand. On 2/16/26 at 11:09 a.m. Resident #34's nebulizer reservoir was l attached to the mask sitting on the back corner of the night stand. On 2/17/26 at 9:41 a.m. Resident #34's nebulizer reservoir was attached to the mask but not to the nebulizer tubing. The mask and reservoir were sitting on the back corner of the night stand. V. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 2/18/26 at 10:20 a.m. CNA #1 said the CNA and nurse were responsible for ensuring the nebulizer equipment was cleaned and stored properly. She said the staff used sanitary wipes to clean the mask and then dried it. She said the reservoir should be rinsed out and dried as well. She said she was not sure how or where it should be stored. Registered nurse (RN) #1 was interviewed on 2/18/26 at 10:30 a.m. RN #1 said the nurse was responsible for cleaning the nebulizer equipment after each use. He said the mask and reservoir should be rinsed out and left on a clean surface to air dry. He said after it dried it should be stored in a plastic bag. He said the equipment should not be stored in a drawer with other items or on top of the night stand. He said earlier in the morning he observed Resident #34's nebulizer mask and reservoir were not stored properly and discarded it in the trash can. He said after observing Resident #27's nebulizer mask and reservoir were not stored in the top drawer of her night stand, not stored properly, he discarded it in the trash can.The director of nursing (DON) was interviewed on 2/18/26 at 10:47 a.m. The DON said the nurse was responsible for cleaning the nebulizer equipment. She said it should be rinsed out after use and air dried on a clean surface. She said she was not sure how it should be stored. She said she was not sure how other nurses would know if the equipment was clean or not. The DON was interviewed a second time on 2/18/26 at 10:47 a.m. The DON said she spoke with the facility respiratory contractor and was told after the equipment was air dried it should be stored in a clean dry place. She said it should not be stored in a drawer with other items. The regional clinical nurse was interviewed on 2/18/26 at 1:22 p.m. The regional clinical nurse said the facility added storing the nebulizer equipment in a bag after being cleaned and dried to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse competency checklist. She said all nurses were educated that when giving a nebulizer treatment, and the equipment was not stored in a bag. She said the staff should rewash the equipment or replace it prior to administering the nebulizer treatment. She said a performance improvement plan (PIP) was initiated 2/18/26 and an audit of all residents using respiratory equipment. She said starting 2/18/26 all nurses would be educated on the proper cleaning and storage of the nebulizer equipment.