

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  City Scape Rehabilitation & Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  3345 Forest St Denver, CO 80207	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</b></p> <p>Based on record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#1) of three residents reviewed for accidents out of four sample residents.</p> <p>Specifically, the facility failed to implement person-centered fall interventions in a timely manner.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Fall/Accident Assessment Prevention and Review policy, undated, was provided by the nursing home administrator (NHA) on 5/1/25 at 12:42 p.m. It read in pertinent part:</p> <p>The goal of the facility is for residents to remain as free from falls and accidents as possible. To provide guidelines for the assessment, prevention and review of falls and/or accidents.</p> <p>The interdisciplinary team (IDT) will review the forms at the morning quality improvement meeting to determine what immediate action may be necessary.</p> <p>The IDT will again review the forms in greater detail at the weekly IDT meeting. Data collected will be reviewed in an attempt to determine causal factors and trends. Specific approaches to prevent further falls will be determined based on the reasons for the falls as determined in the assessment and review. The care plan will be updated and interventions will be put into place.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease with dyskinesia (involuntary movements), difficulty in walking, generalized muscle weakness, lack of coordination and chronic pain.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 2/9/25 minimum data set (MDS) assessment revealed that Resident #1 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 required partial to moderate assistance for sit-to-stand and all surface transfers.</p> <p>B. Resident interview</p> <p>Resident #1 was interviewed on 5/1/25 at 12:00 p.m. Resident #1 said she fell a lot because she waited for help from staff for a long time and transferred herself. She said she did not have fall interventions in place.</p> <p>C. Record review</p> <p>Resident #1's fall care plan, revised 4/25/25, revealed the resident was a high fall risk due to having Parkinson's disease, gait and balance issues and using psychoactive drugs. Interventions were documented as anticipating and meeting the resident's needs, ensuring the call light was within reach and encouraging the resident to use it, educating the resident about safety and what to do if a fall occurred, encouraging the resident to participate in strengthening activities, following the facility's fall protocol, physical therapy to evaluate and treat the resident as ordered and as needed and reviewing information on past falls to determine the cause of the fall.</p> <p>Review of Resident #1's electronic medical record (EMR) revealed the following:</p> <p>Resident #1 had an unwitnessed fall in her room with no injuries on 9/2/24 at 4:30 p.m.</p> <p>A fall intervention was implemented on 10/7/25 to remind and encourage the resident to lock her wheelchair brakes before she transferred herself.</p> <p>-However, the facility did not implement the fall intervention until 35 days after the resident's fall on 9/2/24.</p> <p>Resident #1 had an unwitnessed fall in her room with no injuries on 10/1/24 at 7:00 p.m.</p> <p>A fall intervention was implemented on 10/7/24 for Resident #1 to have a restorative transfer program that focused on consistently locking her wheelchair brakes.</p> <p>-However, the facility did not implement the fall intervention until six days after the resident's fall on 10/1/24 and three days after she sustained another fall on 10/4/24 (see below).</p> <p>Resident #1 had an unwitnessed fall with no injuries in her room while reaching for her water pitcher on 10/11/24 at 3:50 p.m.</p> <p>A fall intervention was implemented on 10/17/24 to ensure frequently used items were within the resident's reach.</p> <p>-However, the facility did not implement the fall intervention until six days after the resident's fall on 10/11/24.</p> <p>Resident #1 had an unwitnessed fall in her room with no injuries on 12/16/24 at 4:48 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A fall intervention was implemented on 1/15/25 for physical therapy to evaluate and treat the resident for strengthening.</p> <p>-However, the facility did not implement the fall intervention until 30 days after the resident's fall on 12/16/24.</p> <p>Resident #1 had a witnessed fall with a skin tear to her left shin while trying to turn off the bedroom light on 4/4/25 at 9:15 p.m.</p> <p>A fall intervention was implemented on 4/24/25 to educate the resident to ensure she was fully in bed and sitting upright before reaching for the light.</p> <p>-However, the facility did not implement the fall intervention until 20 days after the resident's fall on 4/4/25.</p> <p>Resident #1 had an unwitnessed fall with no injuries on 4/5/25 at 3:45 p.m. while sliding out of bed.</p> <p>A fall intervention was implemented on 4/24/25 to encourage the resident to remain centered and properly positioned in bed.</p> <p>-However, the facility did not implement the fall intervention until 19 days after the resident's fall on 4/5/25.</p> <p>III. Staff interviews</p> <p>The NHA and the assistant director of nursing (ADON) were interviewed together on 5/1/25 at 12:42 p.m. The NHA said implementing a fall intervention a week or more after a resident's fall was not prompt and interventions needed to be implemented sooner.</p> <p>The ADON said interventions needed to be implemented as soon as possible to help prevent another fall and to ensure the resident benefited from the fall intervention.</p>