

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 07/01/2025
NAME OF PROVIDER OR SUPPLIER City Scope 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure three (#7, #3 and #5) of four residents reviewed for abuse out of seven sample residents were kept free from abuse. On 5/21/25 Resident #7 was physically abused by Resident #2. Resident #2 used a belt to hit Resident #7 on top of his head and struck Resident #7 with his belt buckle. Resident #7 sustained a laceration to his head, requiring transfer to the emergency room where Resident #7 received five sutures. Additionally, Resident #5 was physically abused by Resident #1 on 3/22/25 and Resident #3 and Resident #1 were physically abused by each other on 5/3/25. Specifically, the facility failed to: -Protect Resident #7 from physical abuse by Resident #2; -Protect Resident #5 from physical abuse by Resident #1; and, -Protect Resident #3 and Resident #1 from physical abuse by each other.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse Neglect and Exploitation policy, dated 5/16/25, was provided by the nursing home administrator (NHA) on 6/30/25 at 3:00 p.m. The policy read in pertinent part,</p> <p>&ldquo;It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>&ldquo;The facility will develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident</p> <p>property. Establish policies and procedures to investigate any such allegations, and establish coordination with the QAPI (quality assurance and performance improvement) program.</p> <p>&ldquo;New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. Existing staff will receive annual education through planned in-services and as needed.</p> <p>&ldquo;The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.&rdquo;</p> <p>II. Incident of physical abuse of Resident #7 by Resident #2 on 5/21/25</p> <p>A. Facility investigation</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/21/25 facility investigation was received from the NHA on 6/30/25 at 1:25 p.m. The investigation documented that Resident #2 and Resident #7 were roommates in a double occupancy room. On 5/21/25 at 4:00 a.m. Resident #7 began using profanity and shouting at Resident #2 causing Resident #2 to become upset. Resident #2 used a belt to hit Resident #7 on top of his head and struck Resident #7 in the head with the belt buckle.</p> <p>The investigation documented facility staff responded to the altercation and separated the residents. The nurse completed an assessment on both residents and documented that Resident #7 was bleeding from his head as a result of being hit on his head with the belt buckle. Resident #7 was sent to the emergency room for treatment. Resident #2 had no injuries.</p> <p>Resident #7 returned to the facility on 5/21/25 with five sutures on the left side of his scalp as a result of the laceration sustained from the belt buckle. Resident #7 was placed in a different room upon his return to the facility and Resident #2 was continued on one-on-one staff supervision.</p> <p>The investigation documented Resident #7 was interviewed by the NHA on 5/21/25 at 9:30 a.m. Resident #7 said he felt comfortable and safe in the facility. Resident #7 was not able to explain what happened and had no memory of the altercation.</p> <p>The investigation documented Resident #2 was interviewed by the NHA on 5/21/25 at 10:00 a.m. Resident #2 said Resident #7 cursed at him causing Resident #2 to become upset. Resident #2 was not willing to explain the event and said he was sorry for what he did. Resident #2 said he did not mean to hurt Resident #7.</p> <p>The facility investigation indicated physical abuse was substantiated.</p> <p>B. Resident #2 (assailant)</p> <p>1. Resident status</p> <p>Resident #2, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included schizophrenia (mental illness), anxiety and dementia.</p> <p>The 4/29/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #2 was independent with ambulation and hygiene, however he was on one-to-one supervision by staff for a history of elopement.</p> <p>The MDS assessment documented the resident had no physical or behavioral symptoms directed towards others during the assessment look back period.</p> <p>2. Record review</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The behavioral care plan, revised 7/17/24, revealed Resident #2 could have behavioral outbursts related to schizophrenia exhibited by anger, poor impulse control and physical aggression toward staff and other residents. Pertinent interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness of medications (initiated 7/17/24), intervening immediately if potential for abuse was observed (initiated 8/6/24), observing interactions with other residents to ensure the residents’ safety and removing the resident from situations that may result in harm to residents immediately (initiated 8/6/24), when the resident became agitated, intervening before the agitation escalated and guide the resident away from sources of distress and engaging the resident calmly in conversation (initiated 7/17/24).</p> <p>-The care plan did not reveal documentation to indicate the interventions were reviewed following the incident for effectiveness of the current interventions or that additional interventions were implemented to prevent reoccurrence of the incident.</p> <p>The 5/1/25 behavioral progress note, documented at 5:05 p.m., revealed Resident #2 refused oral psychiatric medication recently. The nurse on duty educated Resident #2 on medication necessity and side effects of missing scheduled medication, especially psychotropic medications. The physician had been notified that day (5/1/25) and had assessed and educated the resident. A psychiatric nurse practitioner was additionally notified and assessed the resident that day (5/1/25) The resident still refused his medications, said he was feeling good and he did not need any medication messing with his head. A new physician’s order was received to administer Resident #2’s psychotropic medication via an intramuscular route (injection into the muscle).</p> <p>A nurse progress note, dated 5/21/25 at 4:00 a.m., revealed the one-to-one caregiver for Resident #2 called the nurse on duty to notify the nurse of a resident to resident altercation. Resident #7 was found by the nurse on duty lying on his bed and was noted to have active bleeding from the left side of his head. The physician was informed of the altercation. The physician declined for Resident #2 to be transported to the ER for psychiatric evaluation. Resident #2 was placed in a private room until he could be evaluated by a physician. Resident #2 appeared saddened by his actions.</p> <p>Review of Resident #2’s electronic medical record (EMR) revealed Resident #2 was monitored for 72 hours after the altercation with Resident #7 on 5/21/25 and no additional behaviors were documented.</p> <p>C. Resident #7 (victim)</p> <p>1. Resident status</p> <p>Resident #7, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included traumatic brain injury, schizophrenia and dementia.</p> <p>The 4/23/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of four out of 15. Resident #7 required maximum staff assistance with chair to chair transfers and bathing.</p> <p>The MDS assessment documented the resident had no physical and behavioral symptoms directed towards others during the assessment look back period.</p> <p>2. Record review</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The behavioral care plan, initiated 11/1/23, revealed Resident #7 had the potential to be verbally aggressive toward other residents related to impulse control and a diagnosis of schizophrenia. Pertinent interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness of medications (initiated 11/1/23), intervening before agitation escalated when the resident was agitated (initiated 11/1/23), observing for target behaviors, such as refusal of care, verbal aggression toward staff and/or other residents and crying and reporting observed behaviors to the nurse (initiated 8/7/24), observing interactions with other residents, and removing Resident #7 from the situation if signs of frustration or agitation were noted (initiated 8/7/24).</p> <p>-The care plan did not reveal documentation to indicate the interventions were reviewed following the incident for effectiveness of the current interventions or that additional interventions were implemented to prevent reoccurrence of the incident.</p> <p>A nurse progress note, dated 5/21/25 at 4:00 a.m., revealed the one-to-one caregiver for Resident #2 called the nurse on duty to notify the nurse of a resident to resident altercation. Resident #7 was found by the nurse on duty lying on his bed and was noted to have active bleeding from the left side of his head. The nurse on duty applied pressure to stop the bleeding with no effect. Resident #7 was sent out to the emergency room for treatment.</p> <p>A nurse progress note, dated 5/21/25 at 4:30 a.m. revealed the director of nursing (DON), the NHA, the resident's representative and the physician were called to report the alleged altercation involving Resident #7 and Resident #2.</p> <p>A nurse progress note, dated 5/21/25 at 8:12 a.m. revealed Resident #7 returned from the emergency room with a laceration to his left scalp with five sutures.</p> <p>Review of Resident #7's EMR revealed the resident was monitored for neurological changes and psychosocial distress for 72 hours after the 5/21/25 incident with Resident #2. Resident #7 denied pain or feeling afraid of other residents.</p> <p>D. Staff interviews</p> <p>Nurse aide (NA) #2 was interviewed on 6/30/25 at 11:45 a.m. NA #2 said he was hired as the one-to-one caregiver for Resident #2 on the dayshift around November 2024 months ago due to the resident's history of elopement. NA #2 said he heard about the incident between Resident #2 and Resident #7. NA #2 said he had not witnessed any physical aggression from Resident #2 towards other residents or staff.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 6/30/25 at 4:40 p.m. LPN #2 said after the incident with Resident #2 and Resident #7, the facility continued one-to-one staff monitoring for Resident #2 to ensure no other altercations would occur. LPN #2 said before or after the incident, she had not observed any aggression from Resident #2 towards other residents or staff.</p> <p>The DON was interviewed on 6/30/25 at 4:52 p.m. The DON said Resident #2 had a history of wandering throughout the facility and attempting to leave the facility without supervision. The DON said Resident #2 had a care plan for physical aggression toward others and was assigned a one-to-one caregiver to monitor the resident for elopement attempts.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said he was contacted the morning of the altercation (5/21/25) between Resident #2 and Resident #7. The DON said the two residents were separated and an investigation was started immediately. The DON said the care plans were updated for both residents involved with new interventions to keep the residents safe. He said the nursing staff were educated regarding the residents' past behavioral histories along with the new interventions for the residents.</p> <p>-However, review of Resident #2 and Resident #7's care plans did not reveal new interventions that were added following the 5/21/25 incident between the residents or documentation to indicate the care plans were reviewed following the incident for effectiveness of the current interventions (see record review for Resident #2 and Resident #7 above).</p> <p>NA #1 was interviewed on 6/30/25 at 8:14 p.m. NA #1 said both Resident #2 and Resident #7 had resided in the same room. NA #1 said she was assigned as the one-to-one caregiver for Resident #2, due to his history of elopement, on the overnight shift when the altercation occurred (5/21/25). NA #1 said she was sitting outside of Resident #2 and Resident #7's room when she heard yelling coming from inside the room. NA #1 said the residents' room door was closed at the time of the incident. NA #1 said when she went inside of the room, she witnessed Resident #7 bleeding from his head and went to alert the nurse. NA #1 said she had not known that she needed to leave the door open while being a one-to-one caregiver because she had not received any training from the facility before or after the incident happened. NA #1 said both residents usually got along just fine.</p> <p>The NHA and the regional clinical resources (RCR) were interviewed together on 7/1/25 at 10:05 a.m. The NHA said staff responded promptly to the altercation and separated Resident #7 and Resident #2 for safety. The NHA said the investigation was started on 5/21/25 and all involved staff were interviewed. The NHA said Resident #2 had a history of elopement behaviors and that the facility had implemented a one-on-one caregiver prior to the resident's altercation with Resident #7. The NHA said a one-to-one caregiver for a resident should always be able to visualize the resident for safety and to verbally intervene before any physical aggression occurred. The NHA said after the 5/21/25 incident, Resident #2 and Resident #7 had no additional aggressive behaviors.</p> <p>The RCR said she was unsure if staff received training on the one-to-one caregiver policy because the facility changed ownership in May 2025, however, she said the facility planned to provide training to all nursing staff going forward. The RCR said the one-to-one caregiver (NA #1) should have had Resident #2 and Resident #7's door open at the time of the altercation. The RCR said both of the residents would have their care plans updated to address the behaviors displayed during the altercation on 5/21/25.</p> <p>III. Incident of physical abuse of Resident #5 by Resident #1 on 3/22/25</p> <p>A. Facility investigation</p> <p>The 3/22/25 facility investigation of the incident involving Resident #5 and Resident #1 was provided by the NHA on 6/1/25 at 4:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation documented that on 3/22/25 at approximately 2:00 p.m., registered nurse (RN) #1 reported an incident involving Resident #5 and Resident #1 to the former NHA. RN #1 stated that yelling was heard from the memory care unit at approximately 2:00 p.m. on 3/22/25. Resident #1 was observed on the floor, lying on his right lateral side, with Resident #5 on the floor as well, in the main hallway of the memory care unit. Resident #1 was observed aggressively grabbing and kicking Resident #5. Staff members immediately separated both residents to different areas within the memory care unit. Resident #1 was placed back into his wheelchair and Resident #5 was placed on a chair. Resident #5 had a scratch on his ear and Resident #1 had a scratch on his nose.</p> <p>The investigation documented that certified nurse aide (CNA) #3 was in the living room area of the memory care unit when Resident #1 came out of his room in his wheelchair. Resident #1 wheeled himself into the living room area and next to where Resident #5 was sitting. Resident #1 then stood up from his wheelchair and grabbed Resident #5. Resident #5 tried to stand up and both Resident #5 and Resident #1 fell to the floor. Both residents started kicking and holding each other while on the floor. Resident #5 and Resident #1 were separated from each other, with Resident #1 being taken out of the memory care unit. Both residents were assessed for injuries. Resident #1 was transported to the hospital by ambulance for evaluation of aggressive behavior.</p> <p>The investigation documented the former NHA interviewed Resident #5 about the incident on 3/22/25. Resident #5, when asked what happened, stated that he was attacked with a knife and now his ear was bleeding. Then Resident #5 stated that he did not know what happened.</p> <p>The investigation documented the former NHA stated that he received a call from the facility about an incident involving Resident #5 and Resident #1. When he arrived at the facility, he noticed Resident #1 sitting in his wheelchair at the nurses station with the nurse cleaning an abrasion on the left side of his nose.</p> <p>The former NHA interviewed Resident #1 on 3/22/25 at 3:00 p.m. about the incident. Resident #1 was not able to answer any questions during the interview. Resident #1 appeared frustrated and was still agitated. A physician's order was placed by the physician to send Resident #1 to the hospital for evaluation of aggressive behavior.</p> <p>Resident #1 was placed on a one-to-one basis and physician and nurse practitioner (NP) were called for behavioral assessment.</p> <p>The facility's conclusion was that they were unable to substantiate a willful act of physical abuse in a resident-to-resident altercation as neither Resident #5 or Resident #1 could recall the situation upon interview.</p> <p>-However, physical abuse occurred because Resident #1 grabbed Resident #5 and pulled him to the ground.</p> <p>B. Resident #1 (assailant)</p> <p>1. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 CPO, diagnoses included encephalopathy, vascular dementia without other behavioral disturbances, cerebral infraction and difficulty walking.</p> <p>The 6/16/25 MDS assessment indicated that the BIMS assessment was not unable to be completed because the resident was rarely/never understood. According to the staff assessment for mental status, the resident had short term and long term memory problems and his cognitive skills for daily decision making were moderately impaired. He required maximal staff assistance for most activities of daily living (ADL) and moderate staff assistance with transfers and ambulation.</p> <p>The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms directed toward others during the assessment look back period.</p> <p>2. Record review</p> <p>The behavior care plan, revised 6/2/25, revealed Resident #1 had a history of behavior problems with confusion and dementia. He paced the facility and tried to enter areas that were for staff, and enter other residents' rooms. He would rummage and take things that did not belong to him. He had also exhibited impulsive behaviors when attempting to complete inappropriate tasks such as leaving the facility or entering residents' rooms. He had thrown items, rammed into things, or struck out at residents or staff. Pertinent interventions included providing one-to-one staff monitoring, frequent checks, redirecting the resident, maintaining the resident's personal space, monitoring, recording, and reporting any behavior to the physician of the resident harming others, and monitoring for increased anger, labile mood or agitation, if the resident felt threatened, or was thinking was thinking of harming someone.</p> <p>A note, dated 3/22/25 and attached to the facility's investigation report documented Resident #1 was taken off the unit (memory care unit) to de-escalate, as he continued to seek out Resident #5 and was striking out and aggressive towards staff. The on-call physician was notified and verbal orders were received for Resident #1 to be transferred to the hospital and to administer Ativan to the resident every six hours as needed for agitation for 48 hours. Resident #1 was transferred to the hospital by emergency medical services (EMS) for increased behaviors of combativeness and agitation at approximately 2:45 p.m.</p> <p>A skin assessment for Resident #1, dated 3/24/25, two days after the incident with Resident #5, noted Resident #1 had bilateral bruising on his forearms and a scabbed open scratch that was being monitored and had treatment orders. Additionally, a right upper lip abrasion was noted, reportedly sustained during a resident-to-resident altercation. The resident declined to shower but was receptive to a bed bath. The skin assessment revealed warm, dry, and clean, and mucus membranes that were clean, moist, and pink. There were no signs or symptoms of infection. The resident denied any pain or discomfort associated with the wound areas. Treatment was administered to the wound areas with vitamin A&D ointment twice daily per physician orders. The resident displayed cooperation throughout care.</p> <p>C. Resident #5 (victim)</p> <p>1. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #5, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included cognitive communication deficit, adjustment disorder with mixed anxiety and depressed mood and Alzheimer's disease with late onset.</p> <p>The 6/5/25 MDS assessment revealed Resident #2 had severe cognitive impairments with a BIMS score of six out of 15. The resident required moderate staff assistance with ADLs and was able to perform sit-to-standing transfers and ambulate a distance of 10 feet without direct staff assistance, utilizing a walker for support.</p> <p>The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms directed toward others during the assessment look back period.</p> <p>2. Record review</p> <p>-Review of Resident #5's electronic medical record (EMR) revealed there was no documentation related to the incident with Resident #1 on 3/22/25.</p> <p>-Review of Resident #5's comprehensive care plan revealed there was no care plan focus for behaviors.</p> <p>IV. Incident of physical abuse between Resident #3 and Resident #1 on 5/3/25 at 10:00 a.m.</p> <p>A. Facility investigation</p> <p>The 5/3/25 facility investigation was provided by the NHA on 6/30/25 at 4:00 p.m.</p> <p>The investigation revealed that Resident #1 got into an altercation and with Resident #3 and both residents were grabbing/scratching each other. Staff were not sure what precipitated the altercation. The residents were kept separated, and RN #1 spoke to them separately. The residents were calm and RN #1 did skin assessments for both residents, noting scratches on Resident #1. Staff members did not witness what started the incident between Resident #1 and Resident #3. Staff members could not provide accounts of what happened or who was the aggressor in the incident.</p> <p>The investigation documented staff heard yelling from the memory care unit at 10:05 a.m. and observed Resident #3 and Resident #1 in the dining room. The residents appeared agitated and Resident #3 had a superficial scratch mark, with intact skin, on his left forearm. Resident #1 had a skin tear to his right forearm. Resident #3 was separated from Resident #1 and both residents were placed on fifteen-minute checks for seventy-two hours. Resident #3 claimed Resident #1 hit him.</p> <p>The investigation documented the NHA interviewed certified nurse aide (CNA) #3 on 5/3/25 at 10:40 a.m. about the incident between Resident #1 and Resident #3. CNA #3 said she heard and saw another staff member trying to separate the residents around 10:00 a.m. She said she saw Resident #1 scratching Resident #3 and staff members pulled Resident #1's wheelchair away from Resident #3.</p> <p>The investigation documented the facility substantiated physical abuse by Resident #3 and Resident #1.</p> <p>B. Resident #1 (assailant and victim)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. Record review</p> <p>-Review of Resident #1's EMR revealed there was no documentation related to the incident with Resident #3 on 5/3/25.</p> <p>C. Resident #3 (victim and assailant)</p> <p>1. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses including dementia without behavioral disturbance, lack of coordination, and cerebral infarction without residual deficits. He required maximal staff assistance for most ADLs and transfers.</p> <p>The 6/20/25 MDS assessment indicated the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15.</p> <p>The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms directed toward others during the assessment look back period.</p> <p>2. Record review</p> <p>The psychiatric nurse practitioner (NP) was contacted by the assistant director of nursing (ADON), on 5/4/25, concerning the altercation involving Resident #3 and another resident (Resident #1) within the memory care unit. The communication included the suggestion that a review of the resident's current psychiatric medications might be beneficial. The NP confirmed her intent to perform a direct evaluation with Resident #3 upon her availability at the facility.</p> <p>-Review of Resident #3's comprehensive care plan revealed there was no care plan focus for behaviors.</p> <p>V. Staff interviews</p> <p>CNA #1 was interviewed on 6/30/25 at 3:15 p.m. CNA #1 said a physical altercation occurred between Resident #5 and Resident #1 in March 2025. CNA #1 said Resident #5 showed no behavioral changes afterward, and the residents involved no longer interacted with each other or appeared to have a memory of the incident. CNA #1 said the incident was reported to the administration who then investigated the incident.</p> <p>The NHA was interviewed on 7/1/25 at 12:00 p.m. The NHA said he was not the NHA during the incidents involving Resident #5, Resident #1 and Resident #3. He said residents should be monitored for a continuous 72-hour period following a resident-to-resident altercation, ensuring their emotional and psychological stability.</p> <p>The NHA said the policy on how to manage and respond to resident-to-resident altercations was available to staff for reference and training.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER City Scape Rehabilitation & Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3345 Forest St Denver, CO 80207	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA said walkie-talkies might be beneficial for staff to have available when critical or emergent situations arose with residents, such as physical altercations, in order to ensure quicker response times from other staff and improve coordination with staff members.said walkie-talkies might be beneficial for staff to have available when critical or emergent situations arose with residents, such as physical altercations, in order to ensure quicker response times from other staff and improve coordination with staff members.

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#4) of three residents reviewed for accidents out of three sample residents.</p> <p>Resident #4 was admitted on [DATE] for long term care with a diagnosis of dementia. According to the care plan, Resident #4 was determined to be a high fall risk.</p> <p>On 5/28/25 Resident #4 was found on the floor in her room with blood coming from her head. Resident #4 was transported to the hospital for further evaluation. Resident #4 sustained a subdural hematoma (brain bleed) and was diagnosed with a traumatic brain injury. The facility failed to implement person-centered interventions after the resident sustained a fall on 5/28/25. Observations revealed the facility failed to consistently implement the fall interventions on the resident's care plan.</p> <p>Specifically, the facility failed to implement person-centered fall interventions after Resident #4 sustained a fall that resulted in a traumatic brain injury or ensure that staff were consistently following the resident's care planned interventions</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Accident and Supervision policy, implemented 5/16/25, was provided by the nursing home administrator (NHA) on 6/30/25 at 3:44 p.m. It read in pertinent part,</p> <p>The residents' environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.</p> <p>The facility shall establish and utilize a systematic approach to address residents risk and environmental hazards to minimize the likelihood of falls.</p> <p>The facility will provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency and based on the individual residence assess needs and identified hazards in the residence environment.</p> <p>The facility will use monitoring and modification to evaluate the effectiveness of care plan interventions and adjust interventions as needed to make them more effective.</p> <p>Monitoring and modification process include ensuring that interventions are implemented correctly and consistency, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new interventions</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included dementia, muscle weakness, abnormal mobility, confusion and history of falls.</p> <p>The 3/24/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for a mental status (BIMS) score of zero out of 15. She required maximal assistance with toileting hygiene and partial or moderate assistance with chair to bed transfers.</p> <p>The MDS assessment indicated the resident did not have a fall after admission.</p> <p>B. Observations</p> <p>During a continuous observation on 6/30/25, beginning at 12:30 p.m. and ending at 4:30 p.m., the following was observed:</p> <p>At 12:30 p.m. Resident #4 was sitting at the dining room table while eating her lunch. The resident had pink socks on both of her feet that did not have anti-slip material on the bottom of them.</p> <p>At 1:15 p.m. licensed practical nurse (LPN) #1 asked the surveyor to keep an eye on the residents while LPN #1 left the locked unit. No other nursing staff were present in the locked unit.</p> <p>At 1:25 p.m. LPN #1 returned to the secured unit.</p> <p>At 1:30 p.m. Resident #4 was sitting alone at the dining room table after completing her meal. She did not have shoes or socks with anti-slip material on the bottom of them.</p> <p>At 2:00 p.m. Resident #4 was sitting at the dining room table alone. Nursing staff were sitting at a dining room table adjacent to Resident #4 looking at their cell phones.</p> <p>At 3:15 p.m. Resident #4 got up out of her chair independently and ambulated in the hallway with her walker without nursing staff supervision.</p> <p>At 3:30 p.m. Resident #4 was ambulating in the hallway and wandered into another resident's room. Upon prompting, LPN #1 assisted and guided Resident #4 back to a chair in the dining room to watch television.</p> <p>At 3:41 p.m. Resident #4 was observed ambulating in the hallway with visibly wet pants and no staff assistance.</p> <p>C. Record review</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4's fall care plan, revised 6/10/24, revealed the resident was a high fall risk due to having confusion, gait/balance problems, rheumatoid arthritis, incontinence, poor communication and comprehension and being unaware of safety needs. Interventions included anticipating and meeting the resident's needs (initiated 10/21/22), ensuring the call light was within reach and encouraging the resident to use it (initiated 10/21/22), providing her with hands on assistance to stand/sit as needed for safety (initiated 6/10/24), encouraging the resident to participate in strengthening activities (initiated 10/21/22), following the facility's fall protocol (initiated 10/21/22), providing hands on assistance and ensuring that the resident was wearing appropriate footwear such as hard soled non-skid shoes, slippers, or non-skid socks when ambulating (initiated 10/21/22).</p> <p>-However, observations revealed the staff failed to ensure the resident was wearing appropriate footwear such as hard soled non-skid shoes, slippers, or non-skid socks when ambulating (see observations above).</p> <p>The 5/28/25 facility investigation for Resident #4's fall was received from the NHA on 7/1/25 at 9:15 a.m. The investigation documented that on 5/28/25 Resident #4 was reported to have an unwitnessed fall. Resident #4 was found on the floor by nursing staff, next to her bed bleeding from her head. Resident #4 was sent to the hospital for further evaluation and treatment. A computed tomography (CT - medical imaging) scan was completed and revealed the resident sustained two subdural hematomas. The resident returned to the facility the same day.</p> <p>The facility investigation revealed Resident #4 could not describe what had happened. The investigation documented pressure was applied to the area until emergency services (EMS) arrived.</p> <p>The investigation documented Resident #4 was headed to the bathroom around 2:30 a.m. when a staff member heard a noise coming from Resident #4's room. The staff member immediately went into the room and saw Resident #4 on the floor next to bed. The nursing staff member then quickly alerted the nurse on duty. The nursing staff member said the last time she had checked on Resident #4 was around 1:40 a.m. and the resident was noted to be sleeping in her bed with no concerns.</p> <p>A nursing progress note, dated 5/28/25 at 2:50 a.m., revealed Resident #4 was found on the floor next to her bed with blood coming from her left forehead, a swollen black left eye and blood was noted on the floor and on the resident's gown. The RN on duty obtained physician's orders to send Resident #4 to the emergency room for treatment.</p> <p>A nursing progress, dated 5/28/25 at 6:02 p.m., revealed Resident #4 returned to the facility from the emergency room with multiple injuries, including swelling and bruising to the left forehead and left shoulder. Resident #4 also sustained a laceration to the left forehead requiring dissolvable sutures to be placed. Resident #4 returned from the hospital to the facility with a diagnosis of a traumatic brain injury.</p> <p>III. Staff interviews</p> <p>LPN #1 was interviewed on 6/30/25 at 4:10 p.m. LPN #1 said she was told to watch Resident #4 while she was out of bed because of her recent falls. LPN #1 said she was not aware of any additional interventions to prevent Resident #4 from falling again.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-However, LPN #1 asked the surveyor to keep an eye on the residents in the unit, including Resident #4, when she left the secured unit (with no other nursing staff members visible) for 10 minutes (see observations above).</p> <p>The director of nursing (DON) was interviewed on 6/30/25 at 4:42 p.m. The DON said Resident #4 should always have non-slip shoes or socks on her feet because of her recent fall with injury. The DON said there should be at least two staff members visible on the secured unit at all times to monitor and assist the residents. The DON said Resident #4 should not be left alone due to her history of falls with injury. The DON said he would provide additional training for nursing staff regarding fall prevention interventions.</p> <p>The NHA and the regional clinical resources (RCR) were interviewed together on 7/1/25 at 10:05 a.m. The NHA said the facility started an investigation after Resident #4 sustained a fall on 5/28/25. The NHA said the nursing staff did not check on the resident enough because they were not trained on purposeful rounding. The NHA said the nursing staff should monitor residents with dementia and a history of falls to check if they needed assistance.</p> <p>The NHA said after Resident #4 sustained a fall on 5/28/25, Resident #4 had not had another fall. The NHA said there should always be at least two staff members on the secured unit to monitor, provide care to residents and anticipate residents' needs to prevent falls from occurring. The NHA said it was not beneficial to the residents to have been left alone by LPN #1.</p> <p>The RCR said she believed Resident #4's fall was preventable and the staff did not have enough training regarding purposeful and meaningful rounding. The RCR said the facility provided training to all nursing staff on purposeful rounding immediately after the fall occurred. The RCR said the failure of the nursing staff to provide meaningful rounding resulted in Resident #4 sustaining a fall resulting in brain injury.</p>		