

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 7045 Stuart St Westminster, CO 80030	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<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** 51710</p> <p>Based on record review, observation, and interviews, the facility failed to create an environment that protected the right of eight (#1, #2 #3, #4, #5, #6, #7, #8) of eight residents reviewed for abuse out of eight sample residents to be free from abuse. The facility's failure contributed to repeated incidents of abuse and actual harm.</p> <p>Record review and interview revealed Resident #1, under age 35, was blind, nonverbal, non-interviewable, severely cognitively impaired, and dependent on care. On 10/14/24 at 9:39 a.m., a housekeeper observed Resident #2 sexually abusing Resident #1 in her bed. Resident #1 had blood in her incontinence brief and was actively bleeding.</p> <p>A review of the facility's investigation of the 10/14/24 incident revealed Resident #2 had previously engaged in inappropriate sexual behavior toward other male and female residents in the facility. Resident #2 grabbed male Resident #4's breast/chest and torso about a year ago and grabbed male Resident #3's buttocks around a month ago. In addition, Resident #2, known to wander into residents' rooms, entered the room of Resident #5, a female with a history of physical and emotional trauma, on 10/14/24 around midnight (before the incident involving Resident #1), making her feel uncomfortable and leaving when she yelled at him.</p> <p>The facility failed to protect Resident #1 from sexual abuse by Resident #2, protect Resident #3 and #4 from unwanted sexual contact by Resident #2, and protect Resident #5 from Resident #2 entering her room in the middle of the night.</p> <p>The facility conducted training regarding the prevention and detection of sexual assault on 10/16/24 following the incident with Resident #1 and implemented a number of measures to promote resident safety. However, record review and resident interviews revealed abusive incidents continued in the facility after 10/14/24. On 10/23/24, Resident #7 threatened and hit Resident #6 and on 12/10/24, Resident #7 pushed Resident #8 to the ground.</p> <p>Measures taken by the facility after 10/14/24 failed to create an environment that protected residents' right to be free from abuse. This failure created a situation of immediate jeopardy with actual, serious harm for Resident #1 and the likelihood of serious harm for other facility residents if the failure was not immediately corrected.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 06A172
		If continuation sheet Page 1 of 17

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Cross-reference F727 - failure to have a director of nursing (DON) serve on a full-time (40 hrs +) basis when the facility had an average daily occupancy of over 60 residents.</p> <p>Cross-reference F867 - failure to ensure an effective quality assurance program to identify and address facility compliance concerns.</p> <p>Findings include:</p> <p>I. Immediate jeopardy</p> <p>A. Findings of immediate jeopardy</p> <p>The facility failed to develop and implement effective interventions to prevent resident-to-resident abuse.</p> <p>Resident #2, with moderate cognitive impairment, had a history of exhibiting inappropriate sexual behavior towards other residents. On 10/14/24 at 9:39 a.m., a housekeeper observed Resident #2 sexually abusing Resident #1, who was blind, nonverbal, non-interviewable, severely cognitively impaired, and dependent on care.</p> <p>A review of the facility's investigation of the 10/14/24 incident revealed Resident #2 had previously engaged in unwanted sexual behavior toward other male and female residents in the facility. Resident #2 grabbed male Resident #4's breast/chest and torso about a year ago and grabbed male Resident #3's buttocks around a month ago. In addition, Resident #2, known to wander into residents' rooms, entered the room of female Resident #5, who had a history of physical and emotional trauma, on 10/14/24 around midnight (before the incident with Resident #1), making her feel uncomfortable and leaving when she yelled at him.</p> <p>The facility conducted training regarding the prevention and detection of sexual assault on 10/16/24 following the incident with Resident #1 and implemented a number of measures to promote resident safety. However, record review and resident interviews revealed abusive incidents continued in the facility after 10/14/24. On 10/23/24, Resident #7 threatened and hit Resident #6, and on 12/10/24, Resident #7 pushed Resident #8 to the ground.</p> <p>Measures taken by the facility after 10/14/24 failed to create an environment that protected residents' right to be free from all types of abuse. This failure created a situation of immediate jeopardy with actual, serious harm for Resident #1 and the likelihood of serious harm for facility residents if the failure was not immediately corrected.</p> <p>On 12/30/24 at 6:35 p.m., the nursing home administrator (NHA) was notified the facility's failure created an immediate jeopardy situation.</p> <p>B. Facility plan to remove immediate jeopardy</p> <p>On 12/31/24 at 2:48 p.m., the facility submitted a plan to remove the immediate jeopardy. The plan read:</p> <p>Immediate Action:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>All facility employees were immediately re-educated on abuse training. Training was initiated on 12/30/24 at approximately 7:30 p.m. and would continue until complete on or before 12/31/24. Any facility staff unable to complete the training due to pre-approved leave would complete training prior to their next scheduled shift.</p> <p>Abuse training with all residents and their responsible parties would be completed with residents currently in the facility. Training was initiated on 12/30/24 and completed on 12/31/24. Any resident not at the facility would receive abuse training on the same day of their return.</p> <p>The facility temporarily increased resident monitoring. Monitoring was implemented on 12/30/24 and completed on 12/31/24.</p> <p>Increased signage instructing staff how to identify abuse and who/how to report potential signs of abuse were hung throughout the facility. Increased signage was initiated on 12/31/24.</p> <p>The facility's abuse coordinators would complete additional training on occurrence reporting guidelines and investigations. This training was completed on 12/31/24.</p> <p>The facility created and distributed personalized reminder cards to staff that contained the definitions of abuse when to report abuse, who a mandated reporter is, resident rights, and abuse coordinators. This was completed on 12/31/24.</p> <p>C. Removal of immediate jeopardy</p> <p>On 12/31/24 at 2:48 p.m., the NHA was notified that the facility's plan to remove the immediate jeopardy was accepted based on the facility's plan and evidence of implementation of the measures outlined in the plan. However, the deficient practice remained at a G level, isolated, actual harm.</p> <p>II. Facility policy</p> <p>The facility's Abuse policy, revised April 2021, was received from the nursing home administrator (NHA) on 12/30/24 at 5:15 p.m. It read in pertinent part:</p> <p>All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>Interpretation and implementation:</p> <p>If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>Immediately is defined as:</p> <p>-Within two hours of an allegation involving abuse or result in serious bodily injury; or,</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>All allegations are thoroughly investigated. The administrator initiates the investigation.</p> <p>Investigations may be assigned to an individual trained in reviewing, investigation, and reporting such allegations.</p> <p>The individual conducting the investigation as a minimum:</p> <ul style="list-style-type: none"> -Reviews the documentation and evidence; -Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; -Observes the alleged victim, including his or her interactions with staff and other residents; -Interviews the person(s) reporting the incident; -Interviews any witnesses to the incident; -Interviews the resident (as medically appropriate) or the resident's representative; -Interviews the resident's attending physician as needed to determine the resident's condition; -Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; -Interviews the resident's roommate, family members, and visitors; -Interviews other residents to whom the accused employee provides care or services; -Reviews all events leading up to the alleged incident; and, -Documents the investigation completely and thoroughly. <p>The administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.</p> <p>The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.</p> <p>III. Sexual abuse of Resident #1 by Resident #2</p> <p>A. Facility investigation of the 10/14/24 sexual abuse of Resident #1 by Resident #2</p> <p>The social services director (SSD) provided the facility's investigation of the 10/14/24 incident of sexual abuse on 12/30/24 at 11:50 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The abuse investigation, dated 10/14/24, documented the sexual abuse occurred on 10/14/24. It read that registered nurse (RN) #1 was called into Resident #1's room by housekeeping staff, where she found Resident #2 on top of Resident #1 with his pants down by his knees, not wearing underwear, and penetrating Resident #1's vagina with his penis. It was documented that RN #1 immediately separated both residents and took Resident #2 out of the room so she could assess Resident #1.</p> <p>1. Timeline of events on 10/14/24</p> <p>-At 9:39 a.m., Resident #2 was seen entering Resident #1's room (per security camera review).</p> <p>-At 9:44 a.m., housekeeping staff went into Resident #1's room to take out trash and found Resident #2 on top of Resident #1.</p> <p>-At 9:45 a.m., RN #1 removed Resident #2 from being on top of Resident #1.</p> <p>-At 9:45 a.m. Resident #2 was placed on one-to-one supervision.</p> <p>-At 9:50 a.m., RN #1 brought Resident #2 to the NHA, the director of nursing (DON), assistant director of nursing (ADON), and the facility's psychiatric nurse practitioner (NP), who were meeting, and informed them she found Resident #2 on top of Resident #1 having sexual relations.</p> <p>-At 10:00 a.m., the investigation was opened and police were notified.</p> <p>-At 10:05 a.m., the facility called emergency medical services (EMS) to take Resident #1 to the hospital for a sexual assault nurse examiner (SANE) examination.</p> <p>-At 10:11 a.m., EMS arrived to take Resident #1 to the hospital.</p> <p>-At 10:23 a.m., the police department arrived to begin an investigation. The police took over supervision of Resident #2 in the facility upon their arrival, at 10:23 a.m. Resident #2 was not left without a police escort, and EMS required the police department to follow them to the hospital.</p> <p>-At 10:38 a.m., police officers took Resident #2 into the facility's conference room for questioning.</p> <p>-At 10:48 a.m., the police left the room and stated Resident #2 was unable to talk to the police, therefore, they could not arrest him.</p> <p>-At 10:54 a.m., the facility's psychiatric NP provided her clinical presentation of Resident #2 to the police and stated Resident #2 knew what he was doing, and that he knew right from wrong. She also contacted the overseeing psychiatrist who agreed that Resident #2 could identify if he had done something wrong.</p> <p>-At approximately 11:30 a.m., police officers informed the facility's staff that they were not going to arrest Resident #2 and that the NHA and the DON were responsible for changing the safety plan to protect the residents.</p> <p>-At (time undocumented) the psychiatric NP ordered an M1 (mental health) hold for Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-At (time undocumented) EMS arrived at the facility to transport Resident #2 to the hospital for an M1 hold.</p> <p>A formal interview on 10/14/24 at 2:00 p.m. with RN #1 revealed that RN #1 observed Resident #2's penis was in Resident #1's vagina.</p> <p>The facility investigation documented the facility's social services director (SSD) was unable to interview Resident #1 on 10/14/24, time undocumented, due to Resident #1 being cognitively impaired and non-verbal.</p> <p>The investigation documented the facility's SSD was unable to interview Resident #2 on 10/14/24 due to Resident #2 declining to answer questions.</p> <p>2. Interviews</p> <p>The facility conducted interviews with other residents in the facility during the abuse investigation, starting on 10/14/24, and found an additional three residents (#3, #4, and #5) who reported being subjected to inappropriate/non-consensual encounters perpetrated by Resident #2.</p> <p>-The investigation documented an interview with Resident #3 on 10/14/24. The interview revealed Resident #3 said he was touched on his butt, one month ago by Resident #2, and that he had to tell Resident #2 to stop touching him. The facility's SSD followed up with Resident #3 who said he did feel safe in the facility. Resident #3 did not report the incident to staff when it first occurred but said he would tell staff if something happened in the future.</p> <p>The investigation documented an interview with Resident #4 on 10/14/24. The interview revealed Resident #4 said that one year ago, Resident #2 told him he wanted to have sex with him. Resident #4 said he reported the incident to staff when it occurred but staff did not do anything. Resident #4 told the interviewer that he did not trust Resident #2, however, he did feel safe in the facility.</p> <p>The investigation documented an interview with Resident #5 on 10/15/24. The interview revealed Resident #2 had entered Resident #5's room in the middle of the night on 10/14/24 and she felt uncomfortable. No documentation was found that Resident #5 reported the incident to staff before she was interviewed on 10/15/24.</p> <p>3. Facility response</p> <p>The investigation concluded the allegation that Resident #1 was sexually abused by Resident #2 was substantiated, and documented the following follow-up actions were put into place:</p> <p>-The assailant was immediately discharged from the facility;</p> <p>-The facility's medical director/ primary care provider (PCP) was replaced on 10/16/24 (see staff interview below; one person was filling the roles of medical director and PCP in the facility);</p> <p>-The facility conducted room moves to separate male and female residents on separate hallways and the shower rooms were separated and divided by gender;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Vulnerability and risk of aggression screening tools were created on 10/16/24, and assessments were conducted on all residents on 10/17/24;</p> <p>-15-minute checks were initiated on residents deemed vulnerable using the new screening tool.</p> <p>-All residents had a standardized safety plan added to their care plans addressing both vulnerability and risk of aggression scenarios;</p> <p>-All residents, and/or their responsible parties, were notified of the incident and safety measures were put into place to help minimize the risk of occurrence;</p> <p>-The facility requested authorization to run background checks on all residents, as a recommendation from the police department;</p> <p>-Staff training was provided on 10/16/24 that covered signs of sexual assault and abuse; and</p> <p>-The facility's policies were updated to reflect new male and female cohorting and a standardized safety policy.</p> <p>4. Failures in facility response</p> <p>a. The facility's investigation failed to reveal evidence the facility attempted to investigate or address the additional allegations of Resident #2's inappropriate behavior reported during the investigation of the sexual abuse perpetrated on Resident #1 to identify gaps in the facility's ability to protect residents from abuse and to develop effective abuse prevention interventions.</p> <p>-Resident #4, legally blind, said in an interview on 12/30/24 at 1:58 p.m., that there were a lot of aggressive behaviors between residents in the facility. And, when he notified staff of his incident with Resident #2, staff told him only that the two residents should stay away from each other. (See Resident #4's interview below.)</p> <p>-Cross-reference F867; QAPI (quality assurance and performance improvement). The NHA was interviewed on 12/31/24 at 4:33 p.m. The NHA said the QAPI committee had not previously identified concerns related to abuse and the topic of abuse would be a new addition to QAPI meetings moving forward. She said abuse had been cited on the prior recertification survey on 11/30/23 but the action plan was completed and discussed with QAPI. The NHA said the facility finished its plan of correction monitoring for the previously cited abuse citation in January 2024. She said abuse had not been identified by the facility as a concern since that time.</p> <p>b. The facility's investigation documented Resident #2 was experiencing an increase in inappropriate behaviors before and at the time he sexually abused Resident #1. The investigation read the increase in inappropriate behaviors aligned with a prescribed gradual dose reduction (GDR) of his psychotropic medications, first initiated in January 2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>See the interviews below. An interview with the NHA, the DON, and the SSD on 12/30/24 at 4:13 p.m. revealed that Resident #2 had been acting weird for months and that he had six or seven medication changes over the previous six months. The DON said the PCP would review behavior changes with the psychiatry team and continued to make medication changes without the addition of other interventions. The NHA, DON, and SSD agreed that when Resident #2 started exhibiting more behaviors, the GDR was not stopped.</p> <p>A review of Resident #2's record revealed there had been no additional interventions initiated to address the resident's known increase in inappropriate behaviors.</p> <p>B. Resident #2 - perpetrator of sexual abuse involving Resident #1, unwanted sexual contact involving Resident #3, and #4, and entry into Resident #5's room in the middle of the night.</p> <p>1. Resident status</p> <p>Resident #2, age under 65, was readmitted on [DATE] and discharged on [DATE]. According to the October 2024 computerized physician orders CPO, the resident's diagnoses included unspecified personality disorder, other impulse disorders, inhalant use with inhalant-induced persisting dementia, and generalized anxiety disorder.</p> <p>The 9/12/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. He was independent with eating, toileting and toileting hygiene, dressing, bed mobility, and transfers. He required moderate assistance with oral and personal hygiene. No coded behaviors were documented.</p> <p>The resident's behavior care plan, initiated on 8/9/22, documented Resident #2 had a behavior of inappropriately touching staff and other residents in the community related to a diagnosis of impulse disorder. It documented Resident #2 had the potential to be physically aggressive and his triggers were delusions secondary to water intoxication, poor sleep patterns, and peers, and aggression could occur impulsively without warning.</p> <p>-Pertinent interventions included anticipating and meeting Resident #2's needs (initiated 8/9/22), intervening as necessary to protect the rights and safety of others by: approaching/speaking in a calm manner, diverting attention, removing resident from the situation and taking him to an alternate location as needed (initiated 8/9/22), and monitoring Resident #2's location frequently (initiated 8/9/22). The care plan documented staff was to ensure the safety of person(s) who have or have the potential to receive unwanted/unasked-for inappropriate touch, and when the situation warrants, to separate resident(s) and ensure safety with 15-minute checks (initiated 9/30/22). It also documented to report incidents to the authorities/police if, and when, warranted (initiated 10/6/22).</p> <p>The behavior care plan was not updated to include the resident's weird behavior, increase in behaviors, or GDR.</p> <p>The resident's elopement care plan, initiated on 9/8/22, documented Resident #2 was an elopement risk/wanderer related to impaired safety awareness. It documented Resident #2 wanders into others' rooms to look for soda, money, or cigarettes.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Pertinent interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books (initiated 9/8/22), and by utilizing 15-minute tracking to provide increased monitoring (initiated 9/8/22)</p> <p>Resident #2 also had a behavior care plan initiated on 2/21/18 that was documented as resolved on 9/9/22. This care plan documented Resident #2 could be socially inappropriate at times, could be sexual in nature and he could be seen hugging or kissing other female residents or staff.</p> <p>-Pertinent interventions documented were to provide one-to-one supervision as needed to educate Resident #2 on appropriate behaviors with staff and other female residents and to place him on 15-minute tracking for safety if concerns of unsafe sex practices were observed.</p> <p>2. Documentation on 10/14/24</p> <p>A nurse's note, dated 10/14/24 at 1:49 a.m., documented Resident #2 was being monitored for a medication change from Depakote (anti-convulsant medication) to Valproic acid (anti-convulsant medication). It documented Resident #2 took his scheduled medications yet refused his blood sugar check and insulin. It read that Resident #2 had some difficulty falling and staying asleep again that night. The note did not document Resident #2 had entered Resident #5's room around midnight, leaving when yelled at by Resident #5, or document 15-minute checks were initiated because of the inappropriate encounter.</p> <p>A nurse's note, dated 10/14/24 at 12:59 p.m., documented the nurse was called into Resident #1's room by housekeeping where she found Resident #2 on top of Resident #1 with his pants down toward his knees and not wearing underwear. It documented Resident #1's incontinence brief was open. It read the nurse separated both residents and Resident #2 was placed on one-to-one supervision.</p> <p>A psychiatry follow-up note, dated 10/14/24 at 5:15 p.m., documented Resident #2 had a diagnosed psychotic disorder with hallucinations, and he had been non-compliant with his prescribed psychiatric medications. It documented that since the incident on 10/14/24, Resident #2 continued to exhibit episodes of irritability and agitation, making him a continued risk to other residents in the facility. Due to the risk of immediate safety to other residents, an M1 mental health hold was initiated on Resident #2.</p> <p>C. Resident #1 - victim of sexual abuse</p> <p>1. Resident status</p> <p>Resident #1, under age 65, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, the resident's diagnoses included neuronal ceroid lipofuscinosis (nerve cell disorder), autistic disorder, legal blindness, aphasia (the loss of understanding/expressing speech), and major depressive disorder.</p> <p>The 11/7/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. She was dependent on staff for all activities of daily living (ADLs). She had adequate hearing but was unable to speak, rarely able to express her needs and wants (both verbally and non-verbally), and had severely impaired vision. She was sometimes able to understand verbal content.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Park Forest Care Center, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 7045 Stuart St Westminster, CO 80030	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The resident's activities of daily living (ADL) care plan, initiated on 8/31/2020 and revised on 8/25/23, revealed Resident #1 had an ADL self-care performance deficit related to neurological deficits.</p> <p>-Pertinent interventions revealed that Resident #1 was totally dependent on two staff to perform all ADL care.</p> <p>The resident's vulnerability care plan, developed after the 10/14/24 incident, was initiated on 10/17/24 and revised on 11/25/24. It read Resident #1 was at high risk of vulnerability due to significant cognitive impairment, physical disability, and dependence on staff for most or all personal care. It documented that Resident #1 had difficulty understanding or responding to social cues, making Resident #1 more vulnerable to inappropriate behavior by others, with a greater risk for exploitation, neglect, or harm due to an inability to self-advocate.</p> <p>-Pertinent interventions included: ensuring Resident #1's room and common areas were arranged to promote safety, including reducing hazards and ensuring easy access to staff (initiated 10/17/24); checking on the resident every 30 minutes, especially during personal care or social interactions to ensure their needs were being met respectfully (initiated 10/17/24); and assigning a consistent caregiver to minimize confusion and ensure familiarity with the resident's preferences and needs (initiated 10/17/24).</p> <p>2. Documentation on 10/14/24</p> <p>A change in condition note, dated 10/14/24 at 10:41 a.m., documented that a housekeeper called the floor nurse to Resident #1's room after finding Resident #2 on top of Resident #1 sexually assaulting her. The nurse separated the residents. Resident #1 was then sent to the hospital emergency room for a sexual assault nurse examiner (SANE) exam and treatment for injuries and potentially sexually transmitted diseases.</p> <p>A nurse's note, dated 10/14/24 at 1:13 p.m., documented the nurse on duty was called into Resident #1's room by a housekeeper. It read the nurse found Resident #2 on top of Resident #1 with his pants down towards his knees and he was not wearing underwear. It documented Resident #1's incontinence brief was open. It documented the nurse separated Resident #2 from Resident #1 and took him out of the room, and Resident #1's provider, responsible party, the police, and the facility's NHA, DON, and assistant director of nursing (ADON) were notified.</p> <p>A late entry progress note, dated 10/14/24 at 1:39 p.m. documented Resident #2's penis penetrated Resident #1's vagina during the sexual assault.</p> <p>A late entry nurse's note, dated 10/14/24 at 7:50 p.m., documented Resident #1 returned from the hospital and her vital signs were stable.</p> <p>An orders administration note, dated 10/17/24 at 3:05 p.m., documented Resident #1 was screaming and restless, and she was given Oxycodone 5mg ordered as needed for pain.</p> <p>An orders administration note, dated 10/17/24 at 10:30 p.m., documented Resident #1 was given Oxycodone 5mg due to her screaming, moaning, and facial grimacing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A physician note, dated 10/23/24, documented Resident #1's primary care physician (PCP) rounded on her for follow-up after confirmed sexual abuse. It documented Resident #1 seemed uncomfortable for a few days after the assault occurred which was treated with pain medications.</p> <p>IV. Residents subjected to unwanted sexual contact or the unwanted presence of Resident #2</p> <p>A. Resident #3 - victim of unwanted sexual contact</p> <p>1. Resident status</p> <p>Resident #3, age under 60, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, the resident's diagnoses included paranoid schizophrenia (mental disorder), chronic obstructive pulmonary disease (COPD, a lung disorder), and generalized anxiety disorder.</p> <p>The 8/22/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with most ADL tasks or needed set-up assistance No coded behaviors were documented.</p> <p>2. Resident interview</p> <p>Resident #3 was interviewed on 12/30/24 at 1:28 p.m. Resident #3 said A few months ago, he was walking around a corner in the facility, and Resident #2 grabbed his butt. Resident #3 said he felt angry when it occurred, and I wanted to punch him in the face. He said he did not report the incident to staff when it happened because he was too angry. Resident #3 said staff asked him recently (during the facility investigation of the 10/14/24 incident) if anything happened (involving Resident #2) and he reported the incident.</p> <p>Resident #3 said staff did not tell him the incident would be investigated and he had not been questioned further about the incident.</p> <p>B. Resident #4 - victim of unwanted sexual contact</p> <p>1. Resident status</p> <p>Resident #4, age under 70, was admitted on [DATE]. According to the December 2024 CPO, the resident's diagnoses included schizoaffective disorder (chronic mental disorder) depressive type, legal blindness, unspecified depression, and Type 2 diabetes mellitus.</p> <p>The 10/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with all ADLs. No coded behaviors were documented.</p> <p>2. Resident interview</p> <p>Resident #4 was interviewed on 12/30/24 at 1:58 p.m. He said there were a lot of aggressive behaviors between residents in the facility and I just try and stay away. He said he had experienced issues with other residents due to his blindness; residents get mad and sometimes yell at him if he accidentally crosses into their path while walking (Resident #4 was observed ambulating with the aid of a walking stick). Resident #4 did not mention any staff intervention when this occurred.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #4 said two years ago, Resident #2 grabbed his chest and torso area. He said that he felt violated after it occurred. Resident #4 said he notified staff of the incident and was told by staff that he and Resident #2 should stay away from each other.</p> <p>Resident #4 said Resident #2's behavior was triggering because he was sexually assaulted when he was eight years old and he also protected his mother from being physically abused by his father. Resident #4 said he currently feels unsafe and uncomfortable with male caregivers. He said he would not undress or take showers if a male caregiver was present and would refuse care if a male caregiver attempted to help him dress or shower.</p> <p>A review of Resident #4's care plan revealed it failed to address his vulnerability until after the incident on 10/14/24. Further, Resident #4 said staff did not tell him the incident with Resident #2 would be investigated and he had not been questioned further about the incident.</p> <p>C. Resident #5 - victim of unwanted presence of Resident #2</p> <p>1. Resident status</p> <p>Resident #5, age under 30, was admitted on [DATE] and discharged on [DATE]. According to the November 2024 CPO, the resident's diagnoses included unspecified protein-calorie malnutrition, post-traumatic stress disorder, recurrent major depressive disorder, and severe hypoxic-ischemic encephalopathy (brain injury).</p> <p>The 11/20/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. No coded behaviors were documented. The resident was independent with all ADLs.</p> <p>2. Record review</p> <p>A trauma-informed care plan, initiated on 11/2/18, documented that Resident #5 experienced physical and emotional trauma by her father at a very young age. It read Resident #5 had a history of sexual abuse leading to mistrusting males, and that she did better with female caregivers.</p> <p>-Pertinent interventions included reassuring Resident #5 that she was in a safe environment (initiated 6/22/2020) and the facility would attempt to provide female caregivers when she needed assistance with care (initiated 5/5/23).</p> <p>The resident's vulnerability care plan, developed after the 10/14/24 incident and initiated on 10/17/24, documented that Resident #5 was generally independent but could be vulnerable due to factors such as mild cognitive declines, physical limitations, or age-related frailty. It documented Resident #5 had occasional difficulty in self-advocating or making decisions, and had minor risks of exploitation due to confusion o[TRUNCATED]</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>51163</p> <p>Based on record review and interviews, the facility failed to designate a registered nurse (RN) to serve as the director of nursing (DON) on a full-time basis</p> <p>Specifically, the facility utilized the DON as a floor nurse several times a week when the facility's average daily census was over 60 residents.</p> <p>Findings include:</p> <p>I. Facility policy and procedures</p> <p>The Staffing policy, dated 8/1/24, was provided by the NHA on 12/31/24 at 4:28 p.m. It read in pertinent part,</p> <p>The facility will maintain sufficient, competent nursing staff to provide care and services 24 hours per day, seven days per week, in alignment with the resident care needs, acuity levels, and applicable state and federal requirements.</p> <p>II. Record review</p> <p>The facility assessment, reviewed 8/8/24, was provided by the NHA on 12/31/24 at 10:57 a.m. and documented the DON was planned to work as a full-time employee as the DON.</p> <p>The DON position description, undated, was provided by the nursing home administrator (NHA) on 12/31/24 at 4:28 p.m. It read in pertinent part,</p> <p>The DON is responsible for overseeing and managing all aspects of nursing care within the facility. Plays a critical role in ensuring high-quality resident care, compliance with regulations and standards, and effective leadership of the nursing staff. The primary focus is to promote resident well-being, supervise nursing operations, and collaborate with interdisciplinary teams to achieve optimal outcomes.</p> <p>The resident list report was provided by the NHA on 12/30/24 at 10:39 a.m. The list of residents revealed there were currently 80 residents residing in the facility.</p> <p>The December time sheets provided by the NHA on 12/31/24 at 7:00 p.m. documented for the pay period of 12/1/24 through 12/15/24 the DON worked 35.91 hours on the floor and 85.97 in the office.</p> <p>For the pay period of 12/16/24 through 12/31/24 the time sheet documented that the DON worked a total of 47.23 hours on the floor and 91.28 hours in the office.</p> <p>III. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The DON was interviewed on 12/31/24 at approximately 2:00 p.m. The DON said she was the full time DON. She said that due to her working the floor she was behind on her daily DON duties. She said that she was behind on investigating and logging falls due to working the floor.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43950</p> <p>Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety.</p> <p>Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to freedom from abuse, reporting and investigating that rose to the level of immediate jeopardy and created a situation where a serious adverse outcome occurred and caused harm.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Quality Assurance and Performance Improvement Policy, reviewed 12/11/24, was provided by the nursing home administrator (NHA) on 12/31/24 at 7:00 p.m. It read in pertinent part, The purpose of this policy is to establish a systematic, data-driven approach to maintain and</p> <p>improve the quality of care and services provided to residents. This policy aligns with federal requirements and state guidelines to ensure high-quality, person-centered care.</p> <p>The facility will implement a comprehensive Quality Assurance and Performance Improvement (QAPI) program that integrates quality assurance (QA) and performance improvement (PI) principles to enhance resident outcomes, promote safety, and maintain regulatory compliance.</p> <p>The QAPI program will involve all staff, residents, families, and stakeholders in identifying opportunities for improvement and achieving sustainable quality improvements.</p> <p>The QAPI program will address all aspects of care and services, including but not limited to: clinical care, quality of life, resident safety, behavioral health services and infection control.</p> <p>The program will focus on both proactive improvement initiatives and responsive corrective actions.</p> <p>Design and Scope: The QAPI program will be resident-focused, considering resident preferences, needs, and goals. Quality assurance activities will monitor care and identify deviations from standards.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Governance and Leadership: Facility leadership, including the administrator and director of nursing (DON), will champion the QAPI program. The governing body will allocate resources necessary to implement and sustain QAPI initiatives.</p> <p>Data-Driven Decision Making: The program will use quantitative and qualitative data, including incident reports, resident feedback, clinical performance indicators, and survey results.</p> <p>Systematic Analysis: Root cause analysis (RCA) will be conducted for adverse events to identify and address underlying system issues.</p> <p>II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct</p> <p>F600 Free from abuse and neglect</p> <p>During the recertification survey on 8/23/22 F600 was cited at an E scope and severity, a potential for more than minimal harm, isolated.</p> <p>During the recertification survey on 11/30/23 F600 was cited at a D scope and severity, a potential for more than minimal harm, isolated.</p> <p>III. Cross-reference citations</p> <p>Cross-reference F600: The facility failed to ensure residents were protected from resident to resident sexual and physical abuse.</p> <p>The facility's failure to protect residents from resident-to-resident sexual and physical abuse put residents in a situation where a serious outcome occurred and created an immediate jeopardy situation.</p> <p>IV. Staff interviews</p> <p>The NHA was interviewed on 12/31/24 at 4:33 p.m. The NHA said today (12/31/24) was the last day of work for the facility's current medical director (MD #1) and a new medical director (MD #2) started work at the facility tomorrow (1/1/25).</p> <p>The NHA said the QAPI committee met monthly on the second Wednesday of each month. The NHA said QAPI meetings included a full review of the previous month's activities. The NHA said the committee reviewed the reported data for the entire month, such as risk management, resident council and grievances. The NHA said standard items were reviewed, such as admissions, discharges, dietary, weight loss, therapy, restorative programs, falls (including where/why with root cause analysis), hospitalizations, infection control, recruitment/hiring and online continuing education.</p> <p>The NHA said the committee would review each department, such as environmental services, resident council, activities, outings, social services and ancillary. The NHA said the committee created at least one PIP (Performance improvement plan) annually, and as needed, and usually once every quarter to track and trend identified concerns.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The NHA said the QAPI committee had not previously identified concerns related to abuse and the topic of abuse would be a new addition to QAPI meetings moving forward. She said abuse had been cited on the prior recertification survey on 11/30/23 (see above) but the action plan was completed and discussed with QAPI. The NHA said the facility finished their plan of correction monitoring for the previously cited abuse citation in January 2024. She said abuse had not been identified by the facility as a concern since that time.</p>