

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/07/2026
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center LLC		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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews and record review, the facility failed to ensure mechanical equipment was maintained in safe, operating condition for one (#2) of three residents reviewed for mechanical lifts out of three sample residents. Specifically, the facility failed to: -Ensure mechanical lift slings were routinely inspected, maintained and replaced according to the manufacturer's recommendations and professional standards, which resulted in a fall for Resident #2; and, -Ensure mechanical lifts were routinely maintained according to the manufacturer's recommendations. Findings include: I. Professional standardsThe Federal Drug Administration's (FDA) Patient Lift Safety Guide, undated, was retrieved on 7/8/26 from https://www.fda.gov/files/medical%20devices/published/Patient-Lifts-Safety-Guide.pdf. It read in pertinent part, Prepare equipment. Examine sling and attachment areas for tears, holes and frayed seams. Do not use sling with any signs of wear. Keep manufacturer's instructions close to your lift and always follow them. Sling Care. Do not share slings between patients unless slings are properly washed and disinfected. Do not use slings that are frayed, ripped or have holes. If the slings show signs of wear, replace it immediately. Contact information. If you have problems operating your lift, contact the manufacturer or supplier. If you experience an injury, quality problem or use error when using a patient lift, file a voluntary report or online through MedWatch, the FDA safety information and adverse event reporting program. II. Facility policy and procedureThe Preventative Maintenance Program policy and procedure, revised 2/10/26, was provided by the director of nursing (DON) on 7/7/26 at 4:29 p.m. It read in pertinent part, The maintenance director is responsible for developing and maintaining a schedule of maintenance services to ensure equipment is maintained in a safe and operable manner. If preventative maintenance is required, the maintenance director shall decide what tasks need to be completed and how often to complete them. Documentation shall be completed for all tasks and kept in the maintenance director's office for at least three years. III. Manufacturer's instructionsAccording to Invacare's Reliant 450 and Reliant 600 (mechanical lift) user manual (2018), page 33-34, retrieved on 7/8/26 from https://www.vitalitymedical.com/pdf/user-manual-invacare-reliant-600-lift.pdf?srsltid=AfmBOoqJXY8z9DONxs1 The expected service life is eight years, presuming that the product is used daily and in accordance with safety instructions and maintenance instructions stated in this manual. Maintenance Safety Inspection Checklist: Regular cleaning will reveal loose or worn parts, enhance smooth operations and extend the lift expectancy. Follow the maintenance procedures described in this manual to keep your patient lift in continuous service. Sling and hardware. Check all sling attachments each time it is used to ensure proper connection and patient safety. Inspect sling material for wear. Inspect straps for wear. Keep lift and slings clean and in good working order. Any defect should be noted and reported to your dealer as soon as possible. Maintenance for the boom, the hangar bar, actuator assembly, cleaning and slings and hardware is recommended initially. Inspect and adjust monthly. IV. Mechanical (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center LLC		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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift sling and mechanical lift maintenance failuresA. ObservationDuring a facility walkthrough on 7/6/26, an Invacare Reliant 450 mechanical lift was observed on the women's unit at 2:18 p.m. with a handwritten note that read Out of service 6/2/26. Two Invacare Reliant 600 mechanical lifts were observed on the men's unit at 2:22 p.m. -However, there was no maintenance record for the Invacare Reliant 450 mechanical lift on why it was out of service (see interviews below).B. Record reviewThe 2/10/26 witnessed fall incident report revealed licensed practical nurse (LPN) #1 was called to Resident #2's room at approximately 8:00 a.m. by certified nurse aide (CNA) #1. LPN #1 arrived to the room and Resident #2 was on the floor. CNA #1 said Resident #2 fell while transferring from the bed to the chair. CNA #1 said the sling snapped off the mechanical lift. CNA #1 reported the resident fell from the bottom first and then the upper part of his body fell from the lift. The 2/11/26 interdisciplinary (IDT) event note revealed Resident #2's 2/10/26 incident was described as a witnessed fall during a Hoyer lift transfer. The root cause was a malfunction of equipment. The new intervention was that all Hoyer lift slings were replaced.A request of all work orders and routine maintenance records for all three mechanical lifts was made to the nursing home administrator (NHA) on 7/7/26 at 12:30 p.m. The records revealed the following: On 2/11/26, a staff member reported a Hoyer (mechanical) lift was very wobbly and unstable and rated the request a five. On 2/11/2026, a maintenance department employee documented that all bolts were tightened. -However, the record did not reveal which of the three mechanical lifts required service. On 5/28/26, a staff member reported a Hoyer lift's hand-held level that opened the legs often closed when transferring residents, especially the heavy residents and rated the request a four. On 5/28/26, a maintenance department employee documented it as completed. -However, the record did not reveal which of the three mechanical lifts required service and did not describe what was done to fix the mechanical lift. An email revealed an outside maintenance company performed diagnostics for three mechanical lifts on 6/24/26. The email revealed a technician completed the diagnostics and found although the mechanical lifts were older models, they were in proper working order with no issues identified. -However, the facility did not provide documentation to indicate that the three mechanical lifts were routinely inspected and maintained on a monthly basis, per the manufacturer's instructions (see manufacturer's instructions above).C. Facility's plan of correctionThe corrective action plan the facility implemented in response to the mechanical lift sling malfunction involving Resident #2 on 2/10/2026 was provided by the DON on 7/7/26 at 2:00 p.m.The corrective action plan identified the facility became aware of the issue on 2/10/26 and developed a performance improvement plan in response to Resident #2's fall due to the sling snapping. The facility completed education to all clinical staff and a return demonstration of mechanical lift use was completed by all clinical staff. On 2/10/26, the facility provided in-service training for all nursing staff on the facility policy for lifts and safety.The DON or the nursing home administrator (NHA) monitored mechanical lift transfers during rounds weekly for four weeks and then monthly for three months and then quarterly. All mechanical lift slings were monitored by the DON to ensure they are in good working condition for 12 weeks. -However, during the survey, additional concerns related to the failure to maintain mechanical lifts in safe operating condition were observed (see observations above).V. Staff interviewsCNA #2 was interviewed on 7/6/26 at 3:26 p.m. CNA #2 said she last received mechanical lift training in February 2026 or March 2026. She said she had worked at the facility for almost two years. She said each resident had their own sling in their room and in the laundry room. She said if a mechanical lift required repair or maintenance, she notified maintenance through an online system. She said she wrote a description of what was wrong and rated the importance of the request on a scale of one to five. She said if a mechanical lift required repair or maintenance, she rated the request as a five because it was important for the mechanical lift to be (continued on next page)		

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 07/07/2026
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center LLC		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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fixed as soon as possible. CNA #2 said there were two automatic mechanical lifts and one manual mechanical lift. She said one of the mechanical lifts was currently out of order because the legs of the lift were poor quality and unreliable. She said before she used a mechanical lift, she made sure the battery was in operating order, the legs looked okay and the remote worked. CNA #2 said she did not know where the mechanical lift manuals were stored and she said she did not know how to access the manuals. LPN #1 was interviewed via phone on 7/7/26 at 10:11 a.m. LPN #1 said she was the nurse who first found Resident #2 after the resident's fall on 2/10/26. She said the cause of the fall was due to the mechanical lift sling snapping. LPN #1 said she did not look at mechanical lift slings regularly, but more than one CNA had told her the slings were not in good condition. She said if there were any requests for sling replacements, the DON needed to be notified. CNA #1 was interviewed on 7/7/26 at 12:00 p.m. CNA #1 said the mechanical lift sling used to transfer Resident #2 (on 2/10/26) broke and the resident fell when he was close to sitting down on the chair. CNA #1 said she had worked at the facility for two years and the slings were never replaced (prior to the 2/10/26 incident) and they were not in good condition. CNA #1 said before the 2/10/26 incident with Resident #2, there was only one resident who had their own sling. She said for everyone else, staff used whatever sling they could find and there were never enough. CNA #1 said she reported the slings not being in good repair verbally, but she did not document the work order request. CNA #1 said the mechanical lifts frequently required maintenance and they were never fixed. Registered nurse (RN) #1 was interviewed via phone on 7/7/26 at 10:18 a.m. RN #1 said she was working the day of Resident #2's 2/10/26 fall from the mechanical lift. RN #1 said the cause of the fall was the sling stitching fell apart and snapped. RN #1 said she was unsure how long the slings had been in use prior to the 2/10/26 incident. RN #1 said after the incident, all residents who required a mechanical lift received their own slings and were labeled using a Sharpie or a machine label maker. The former director of supplies was interviewed via phone on 7/7/26 at 10:24 a.m. The director of supplies said she stopped working at the facility in December 2025. She said she saw the conditions of the mechanical lift slings and requested the slings to be replaced by asking the maintenance director (prior to the incident with Resident #2 on 2/10/26). The director of supplies said the slings were washed daily and there were holes in the slings and they were old. The maintenance director was interviewed on 7/7/26 at 12:30 p.m. The maintenance director said he had worked at the facility for over 35 years. He said the facility had three mechanical lifts. The maintenance director said he was responsible for the maintenance of the mechanical lifts and the nursing staff was responsible for the maintenance of the mechanical lift slings. The maintenance director said he did not know what the manufacturer's instructions were for how often routine maintenance should be completed on the mechanical lifts. The maintenance director said staff should submit a work order request when maintenance was needed on the mechanical lifts; however, most CNAs told him verbally about a mechanical lift concern while he was in the hallway. The maintenance director said he did not document every time a CNA told him something needed to be fixed on the mechanical lifts. The maintenance director said he should be better at documenting the work orders for the mechanical lifts. The maintenance director said the facility had had the three mechanical lifts for about ten years. He said he did not know the expected service life of the mechanical lifts. The maintenance director said the most frequent mechanical lift maintenance requests CNAs made were that there was hair in the wheels of the mechanical lift or that the mechanical lift's batteries needed to be replaced. The maintenance director said he was not aware one of the mechanical lifts had an out of order sign on it. He said to his knowledge, all mechanical lifts were in working order. The NHA was interviewed on 7/7/26 at 1:46 p.m. The NHA said the maintenance department was responsible for the maintenance of mechanical lifts. He said (continued on next page)		

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 07/07/2026
NAME OF PROVIDER OR SUPPLIER Park Forest Care Center LLC		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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should use the electronic work order process to make mechanical lift maintenance requests. He said the maintenance department should follow the manufacturer's instructions for routine maintenance of the mechanical lifts. The NHA said the 6/24/26 outside diagnostic maintenance of the mechanical lifts was completed because the facility was setting up new systems and they wanted to make sure all equipment was functional. The NHA said nursing staff was responsible for the maintenance of the slings. The DON and the NHA were interviewed together on 7/7/26 at 3:33 pm. The DON and the NHA said the DON was not at the facility on 2/10/26. The DON said the cause of Resident #2 falling to the floor was that the mechanical lift sling was not in good condition. The DON and the NHA said they were unable to verify how long the mechanical lift slings had been in use prior to 2/10/26. The DON said she was responsible for keeping track of all residents who required a mechanical lift sling and what size sling the resident required. The DON said each resident had at least two slings. The DON said there had been no further incidents related to mechanical lift sling failure since 2/10/26. The NHA said the maintenance record documentation should have been more clear in order to determine which mechanical lift was serviced and what maintenance was completed to resolve the work order.		