STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. Building B. Wing	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Park Healthcare and Rehabilitation Center	1667 Saint Paul St Denver, CO 80206

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41172 Based on observations, interviews and record review, the facility failed to ensure residents and or their representatives were provided prompt efforts by the facility to resolve grievances for three (#1, #2 and #3) of three residents out of three sample residents. Specifically, the facility failed to address, resolve, document and follow up on grievances for: -Resident #1 regarding missing medications, call light wait times and schedule to ensure he arrived to dialysis timely; -Resident #2 regarding the staff getting him out of bed, call light wait times and providing showers; and, -Resident #3 regarding extended call light wait times. Findings include: I. Facility policy and procedure The Grievances policy, revised November 2016, was received on 1/11/24 at 3:00 p.m. from the nursing home administrator (NHA). The policy documented in pertinent part, Within three days of receipt of an verbal or written grievance, the Grievance Officer or designee, will give a written explanation of findings and proposed remedies, if any, to the complainant and to the aggrieved party, if other than the complainant. An oral explanation will be provided, along with the written statement whenever possible. II. Resident interviews Resident #1 was interviewed on 1/10/24 at 11:50 a.m. Resident #1 said he had reported concerns with extended call light times over one and a half hours long to the director of nursing (DON) and NHA multiple times. He said the concern had not been addressed and he had received no follow up from the DON or NHA. (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 said he had been out of one of his kidney failure medications,Velphoro, for several weeks. He said the nurse on duty and the DON were aware but he had received no follow up about when the medication would be available (cross reference F760 significant medication errors). Resident #1 said he had dialysis three times per week. He said he was frequently late to dialysis. Resident #1 said the night shift was supposed to get him ready and dressed, and the day shift was supposed to put him in his chair at 6:30 a.m. He said the day shift did not get him in his chair by 6:30 a.m. The resident said the DON was aware of his concern, but there had been no resolution (cross reference F698 dialysis). Resident #1 was interviewed again on 1/11/24 at 3:27 p.m. He said the social worker had come to his room today (1/11/24) and told him he was not allowed to leave messages on the staff's voicemail with his concerns. She handed him several concern forms and told him he needed to fill out a form if he had a concern. Resident #2 was interviewed on 1/10/24 at 12:48 p.m. He said he had reported concerns about extended call light wait times for over an hour to the nurses on duty and the social worker. He said he had not heard any follow up on his concern. Resident #2 said the nursing staff would refuse to get him out of bed, put him back to bed timely, or give him a shower. He said he had reported his concerns to the nurse on duty and the DON. He said there had been no improvement to his concerns. Resident #3 was interviewed on 1/10/24 at 1:22 p.m. He said he had reported concerns with call light wait times up to one and a half hours long to the nurse on duty. He said he had not seen any improvement to the extended call light wait times. IV. Record review Grievance concern forms were requested from the NHA on 1/11/24 at 1:11 p.m. related to the concerns above for Residents #1, #2 and #3. -No grievances or concern forms were received by the end of the survey on 1/11/24. Grievance concern forms were requested from the DON on 1/11/24 at 1:51 p.m. related to the concerns above for Residents #1, #2 and #3. -No grievances or concern forms were received by the end of the survey on 1/11/24. On 10/15/23 at 10:56 p.m., a nursing progress note documented Resident #2 went to the second floor and told the nurse he had been waiting since 7:00 p.m. to be put to bed. The second floor nurse called the 3rd floor where the resident lived but there was no answer. The second floor nurse went to the 3rd floor and informed the 3rd floor nurse the resident had been waiting to go to bed. On 10/23/23 at 12:56 p.m. the social service note documented that Resident #2 had concerns with showers, receiving timely care and feeling his needs overall were being ignored. The SW informed the nurse manager. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, there were no grievances or concern forms completed for Resident #2's concerns. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 1/10/24 at 12:31 p.m. She said she was the nurse for Resident #1. LPN #1 said the resident had been out of his Velphoro medication for a few weeks. She said she did not know if his primary physician was aware. She said the DON was aware. LPN #1 said she had not followed up with the resident regarding the progress on obtaining his medication. LPN #1 said she had worked with Resident #1 during the night shift and day shift. She said she was aware of his concerns with extended call light wait times. She said sometimes he called frequently with his call light for assistance and sometimes he did not. She said he was very picky and liked things done a certain way. She said, as an example, Resident #1 liked the books in his room organized in a certain order. LPN #1 said the resident had expressed concerns with being late for dialysis. She said Resident #1t did not want to get up in his wheelchair before 6:30 a.m. and when the day shift arrived they would get caught up in rounds and not get him up on time. Certified nurse aide (CNA) #1 was interviewed on 1/10/24 at 1:40 p.m. CNA #1 said Resident #2 and Resident #3 had both expressed concerns to her about extended call light times, especially on the night shift. The DON was interviewed on 1/11/24 at 1:51 p.m. She said she was aware of Resident #1's missing medication, Velphoro. She said she was waiting on prior authorization from the insurance provider for the medication. The DON confirmed the resident had not had the medication in several weeks. She said we dropped the ball and too much time had gone by that the resident had not had the medication. She did not know if anyone had followed up with the resident regarding his concern of not having the medication. The DON said she had call light concerns reported to her from Resident #1 and Resident #2 in the past. She thought it was several months ago. She said she did not know if she had grievances reports with follow up regarding call lights. She said she would look. The DON said she was aware of Resident #1's concerns with having been late to dialysis. She said it was the resident that caused the problem. She said he always wanted one more thing done before he could get in his chair. She said 6:30 a.m. was at shift change for the nursing staff and they could not get him up at that time. The DON said she had no grievance report for Resident #1 indicating follow up or attempts to resolve the issue. The DON said she was aware of Resident #2's concerns with not getting out of bed, or being put back to bed timely, as well as his concern with call lights. She said it was a couple of months ago and did not realize it was still a concern. She said she did not have a grievance report on his concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 1/11/24 at 2:38 p.m. She said she started a few weeks ago and had identified grievance reports were not being completed.The NHA said she had not had a chance to put a corrective plan in place yet. She said if a resident had a concern the staff should complete a grievance form for them. She said a copy went to the NHA and to the department head responsible. She said the department responsible then had 72 hours to investigate the concern and respond back to the resident with possible solutions. She said she did not have grievances for Residents #1, #2 or #3, or call lights. The NHA said she had identified that the majority of concerns reported seemed to come from her night shift and she would plan to come in on that shift to observe what was happening.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, record review and interviews, the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for one (#1) of three residents reviewed for dialysis out of three sample residents. Specifically, the facility failed to ensure Resident #1 was ready to leave the facility timely in order to get to dialysis to receive all ordered dialysis treatment. Findings include: I. Facility policy The Dialysis Care policy, revised 7/12/23, was received on 1/11/24 at 3:00 p.m. from the nursing home administrator (NHA). The policy documented in pertinent part, Coordination of dialysis care will include communication about care concerns and appropriate interventions, if dialysis is postponed or canceled the provider will be notified. II. Resident status Resident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2024 computerized physician orders (CPO), diagnoses included end stage renal disease. The 11/24/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required setup assistance with personal hygiene, parietal to moderate assistance with toileting and bed mobility. He required substantial maximum assistance with transfers. The assessment documented the resident was on dialysis. III. Resident interview Resident #1 was interviewed on 1/10/24 at 11:50 a.m. Resident #1 said he had dialysis three times per week. He said he was frequently late to dialysis. Resident #1 said the night shift was supposed to get him ready and dressed, and the day shift was supposed to put him in his wheelchair at 6:30 a.m. He said the day shift did not get him in his chair at 6:30 a.m. IV. Record review The January 2024 CPO documented the resident had physician orders dated 5/25/2023 for dialysis on Tuesday, Thursday and Saturday at 12:10 p.m. The January 2024 CPO documented Resident #1 was to be gotten up by 6:00 a.m. by night shift staff for dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the resident's dialysis was scheduled to begin at 7:30 a.m. not 12:10 p.m. -The resident did not want to sit up in his chair earlier than 6:30 a.m. Dialysis communication records for Resident #1,dated 12/19/23 and 12/26/23, were reviewed on 1/11/24. Both records documented the resident was late for dialysis. The dialysis care plan, initiated 2/26/2020, documented the staff was to ensure the resident was ready for dialysis at 6:30 a.m. On 12/18/23 at 2:43 p.m., the social services progress note documented the resident was non- compliant with his dialysis pick up time. -However, according to a staff interview, the resident did not want to wait for extended periods of time sitting up in his wheelchair for transport to dialysis and the staff frequently got caught up in their rounds and did not have him ready at 6:30 a.m. V. Additional interviews Licensed practical nurse (LPN) #1 was interviewed on 1/10/24 at 12:31 p.m. lpn #1 said the resident had expressed concern with being late for dialysis. She said the resident did not want to get up in his wheelchair before 6:30 a.m. and when the day shift arrived they would get caught up in rounds and not get him up on time. The director of nursing (DON) was interviewed on 1/11/24 at 1:51 p.m. The DON said she was aware of Resident #1's concerns with having been late to dialysis. The DON said the nursing staff told her it was the resident that caused the problem. She said the nursing staff told her Resident #1 always wanted one more thing done before he could get in his chair. She said 6:30 a.m. was at shift change for the nursing staff and they could not get him up at that time. The DON said she had not spoken to the resident about the problem and did not know what his story version was regarding being late. The DON said she had not heard the nursing staff got caught up in their rounds and did not get Resident #1 up timely. The dialysis center clinical manager (DCM) was interviewed on 1/11/24 at 11:20 a.m. She said the resident had dialysis three times per week on Tuesday, Thursday and Saturday at 7:30 a.m. She said Resident #1 was late for almost every session. The DCM said this resulted in the resident having to be taken off dialysis before he had a full session because he started late. The DCM said this meant the resident missed about one and a half hours per week of dialysis. She said receiving the full dialysis time was critical to the resident's health. The DCM said with a shortened dialysis time Resident #1 was not getting enough fluid, chemicals and waste pulled off of his body. She said this could lead to significant issues with his heart and breathing and lead to increased hospitalization s.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of 3 sample residents did not experience a significant medication error. Specifically, the facility failed to ensure that Resident #1 received all doses of his prescribed kidney failure medication, Velphoro, which resulted in a significant medication error of omission. Findings include: I. Facility policy The Medication Administration policy, dated 7/25/19, was received on 1/11/24 at 3:00 p.m. from the nursing home administrator (NHA). The policy documented in pertinent part, Medications will be administered in accordance with written orders authorized by the attending physician. II. Resident status Resident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2024 computerized physician orders (CPO), diagnoses included end stage renal disease. The 11/24/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required setup assistance with personal hygiene, parietal to moderate assistance with toileting and bed mobility. He required substantial maximum assistance with transfers. The assessment documented the resident was on dialysis. III. Record review The January 2024 CPO revealed the following: On 2/13/23 at 4:00 p.m. the resident had an order for Sucroferric Oxyhydroxide (Velphoro) tablet chewable 500 mg (milligram). Give two tablets by mouth three times daily. On 12/28/23 at 5:19 p.m. there was an order to hold the Velphoro because prior authorization was needed. The order listed the start date as 12/28/23 and the end date as 12/31/23. The January 2024 CPO no longer listed an order to hold the medication because the order to hold the medication had ended on 12/31/23. The December 2023 medication administration record (MAR) documented the last time the resident received the medication was 12/24/23, four days prior to the order to hold the medication. IV. Interviews (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was interviewed on 1/10/24 at 11:50 a.m. He said he had been out of one of his kidney failure medications,Velphoro, for several weeks. He said the nurse on duty and the DON were aware but he had received no follow up about when the medication would be available. Licensed practical nurse (LPN) #1 was interviewed on 1/10/24 at 12:31 p.m. LPN #1 said she was the nurse for Resident #1. LPN #1 said the resident had been out of his Velphoro medication for a few weeks. She said she did not know if his primary physician was aware. Looking at her laptop and the resident's orders, she said there was no order to hold the medication. She said the DON was aware. The DON was interviewed on 1/11/24 at 1:51 p.m. She said she was aware of Resident #1's missing medication Velphoro. She said she was waiting on prior authorization. The DON confirmed the resident had not had the medication in several weeks. She said we dropped the ball and too much time had gone by that the resident had not had the medication. The DON said she did not know if the medication was at the facility yet. She said the facility had obtained an order to hold the medication from the primary physician on 12/28/23 while prior authorization was obtained. However, she said that order was to have ended as of 12/31/23 (see record review above). The dialysis center clinical manager (DCM) was interviewed on 1/11/24 at 11:20 a.m. She said she was concerned the resident had not been getting the phosphorus binding medication, Velphoro. The medication removed excess phosphorus from the blood. The DCM said dialysis did not remove phosphorus from the blood like the kidneys. She said the phosphorus would build up in the blood and act as a toxin affecting all the other electrolytes. The DCM said the build up of phosphorus would lead to muscle cramps and pain, bone breaks, joint pain, itching of the skin and many other problems. She said the resident was supposed to take it three times per day. The DCM said the resident reported he had not received the medication for several weeks and the facility said they were waiting on a prior authorization. The DCM said she and several other staff members at the dialysis center had sent the facility the prior authorization multiple times. The DCM called regarding the phosphate level results after the survey exit on 1/18/24 at 9:08 a.m. She said the resident's phosphate level on 12/14/23 was 2.6 mg/dL (milligrams per deciliter). The DCM said on 1/11/24 the phosphate level was 6.0 mg/dL. She said the phosphate level should be less than 5 mg/dL which was the high end of an acceptable range. The DCM said the elevated phosphate level was a result of Resident #1 not receiving the Velphoro. V. Facility follow up On 1/10/23 at 12:02 p.m. a nursing progress note documented the medication would be sent to the facility as of that date, according to the pharmacy.