

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER South Valley Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4450 E Jewell Ave Denver, CO 80222	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 the residents' environment remained as free of accident hazards as possible for one of three shower rooms, 12 of 22 sample resident room sinks and one (#2) of four residents reviewed for accident hazards out of 52 sample residents. Specifically, the facility failed to:-Ensure the water in facility shower rooms had safe bathing temperatures and staff had adequate monitoring equipment; and,-Ensure certified nurse aide (CNA) #5 transferred Resident #2 appropriately, which resulted in a fall for the resident.</p> <p>Findings include:</p> <p>I. Water temperature failures</p> <p>A. Facility policy and procedure</p> <p>The Water Temperatures policy and procedure, revised [DATE], was received from the nursing home administrator (NHA) on [DATE] at 6:35 p.m. It read in pertinent part, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents.</p> <p>Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit (F).</p> <p>Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. If at any time water temperatures feel excessive to the touch, staff will report this finding to their immediate supervisor.</p> <p>2. Observations</p> <p>Water temperatures from random resident rooms and common areas were checked on [DATE] and found the following:</p> <p>At 10:05 a.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 133 degrees F.</p> <p>At 12:46 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 118.6 degrees F.</p> <p>At 12:54 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>125.2 degrees F.</p> <p>At 1:03 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 122.5 degrees F.</p> <p>At 1:20 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured again and found to be 126.9 degrees F.</p> <p>At 1:23 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 122.4 degrees F.</p> <p>At 1:33 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 126.7 degrees F.</p> <p>At 1:37 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 121.1 degrees F.</p> <p>At 1:43 p.m. the temperature of the hot water in room [ROOM NUMBER] was measured and found to be 124.7 degrees F.</p> <p>3. Facility's water temperature monitoring and documentation</p> <p>The facility's water temperature check log was provided by the NHA on [DATE]. The logs documented weekly monitoring of water temperatures in the three facility showers, three resident rooms, the kitchen and the laundry rooms. The log revealed the following:</p> <p>Water temperatures were measured on each floor of the building once per week from [DATE] through [DATE]. The facility water temperature in one of the resident rooms or shower rooms was measured to be below 100 degrees in three of the 11 instances recorded during this period.</p> <p>On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 114.5, 113.6 and 114.3 degrees F respectively.</p> <p>On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 115.3, 115.2 and 114.5 degrees F respectively.</p> <p>On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 116.5, 115.7 and 116.2 degrees F respectively.</p> <p>On [DATE] the water temperatures in the 2nd floor, 3rd floor, and 4th floor shower rooms were measured to be 116.5, 116.2 and 115.8 degrees F respectively.</p> <p>4. Maintenance director interview and observations</p> <p>The maintenance director (MTD) was interviewed on [DATE] at 2:35 p.m. The MTD said the temperatures in his water maintenance logs typically ranged from 114 to 117 degrees F. The MTD said he checked each floor's water temperatures by measuring the temperatures in the shower rooms and one to two resident rooms per floor each week. The MTD said he also checked the water temperatures as needed if anyone reported any concerns. The MTD said he assessed the water temperature by letting the showers run</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Fall Management System policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 6:35 p.m. It read in pertinent part, It is the policy of this facility to provide an environment that remains free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.</p> <p>B. Resident #2</p> <p>1. Resident status</p> <p>Resident #2, age greater than 65, was admitted on [DATE] and expired on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included cauda equina syndrome (dysfunction of the collection of nerves at the end of the spinal cord), right sided hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke), colostomy and malignant neoplasm (cancer) of the bladder.</p> <p>The [DATE] 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. She was dependent on nursing staff for toileting, chair-to-bed transfers and she turned side to side in bed with staff assistance.</p> <p>2. Record review</p> <p>A review of Resident #2's electronic medical record (EMR) revealed the resident sustained a witnessed fall in her room on [DATE] at approximately 10:00 a.m.</p> <p>The [DATE] incident report, provided by the director of nursing (DON) on [DATE] at 5:59 p.m., revealed a CNA reported during the morning transfer the resident's legs gave out and the resident began to slide down the edge of the bed. The CNA lowered Resident #2 down to the ground. According to the incident report, the physician, nurse manager and family were notified, and Resident #2 did not sustain injuries from the fall.</p> <p>-However, the incident report failed to indicate which CNA was involved in Resident #2's fall.</p> <p>Further review of Resident #2's EMR revealed the CNA who worked with the resident on [DATE] was CNA #5.</p> <p>Resident #2's comprehensive care plan, initiated on [DATE] and revised on [DATE], revealed the resident was at risk for falls and has had an actual fall related to impaired mobility, weakness, pain, cauda equina syndrome, asthma, history of cerebrovascular accident (CVA; stroke), sciatica (compression of the sciatic nerve), fibromyalgia (chronic pain disorder) and apraxia (difficulty producing speech). A pertinent intervention, initiated on [DATE], included staff education on the use of the gait belt for transfers and two-person assist due to the resident's severe weakness from cauda equina syndrome.</p> <p>Resident #2's EMR revealed the resident's fall risk assessment score on admission was low, with a score of five. After Resident #2 sustained the fall on [DATE], the fall risk assessment was repeated and determined an at risk score of 10.</p> <p>The [DATE] fall interdisciplinary team (IDT) progress note documented a new intervention to be</p> <p>(continued on next page)</p>		

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