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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on record review and interviews, the facility failed to ensure one (#1) of three residents out of 10 sample residents was free from neglect. Resident #1 suffered an injury of unknown origin to the left forehead, a hematoma (a localized swelling of pooled blood due to injury or trauma), on [DATE] following a shower provided by hospice certified nurse aide (CNA) #1. The resident's son was notified of the forehead hematoma at 3:06 p.m., but the staff did not conduct a full skin assessment on the resident afterward to determine if other injuries were present. Resident #1 sustained a fall three days later, on [DATE]. No injuries were reported. -However, the staff did not conduct a full skin assessment to determine if other injuries were present. On [DATE], a progress note revealed that the resident had a faded yellow bruise to the left shoulder, hip, and a yellow, faded bruise to the left eye. On [DATE], a weekly skin assessment was conducted following a shower. It revealed a green/yellow bruise to the left side of the face, shoulder and breast. An abnormal protrusion to the clavicle (collarbone) was noted. -However, since there were no weekly skin assessments conducted since the original incident on [DATE], the date and origin of the clavicle injury were not identified. Due to the facility's failure to ensure a complete assessment after identifying an injury of unknown origin on [DATE], Resident #1 experienced a delay in care for her clavicle injury which was not discovered until an x-ray was performed on [DATE] and revealed a fracture. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. (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 0600 Level of Harm - Actual harm Residents Affected - Few	I. Incident and injuries of unknown origin between [DATE] and [DATE] Resident #1 sustained an injury of unknown origin on [DATE] and a fall on [DATE]. A full skin assessment documenting the resident's injuries was not performed until [DATE] (nine days later). Due to the facility's failure, the resident's injuries between [DATE] and [DATE] were not identified and treated immediately. Resident #1 experienced a delay in care which resulted in increased pain. -On [DATE], hospice increased the resident's pain medication. -On [DATE] an x-ray was ordered, which, on [DATE], revealed a clavicle fracture. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #1's unknown incident investigation failure between [DATE] and [DATE] was provided by the nursing home administrator (NHA) on [DATE] at 12:16 p.m. The plan revealed the following: A. Corrective action The facility notified the hospice company that the hospice CNA (CNA #1) and the hospice social worker were suspended from entering the facility pending the investigation. The investigation revealed hospice notes documented Resident #1 had a fall on [DATE], but the facility was never notified. On [DATE], the facility terminated their contract with the hospice company due to their lack of communication with the facility and lack of cooperation with the investigation. Education was provided to 23 staff members on [DATE] and included the following: -After a resident fall, call the physician and power of attorney (POA); -Complete neurological checks, fall assessment, post-fall evaluation, skin evaluation and risk management form; and, -Obtain witness statements if applicable. On [DATE] and [DATE], the remaining care staff obtained fall prevention education at the skills fair. Fall binders were created and placed at every nurses station as a reference for the staff and discussed by the unit manager.On [DATE], the facility began an investigation of Resident #1's injuries between [DATE] and [DATE]. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility interviewed all staff on duty who were involved in care for the resident on the day of the fall on [DATE] and a few days prior to the fall. The interviews with the facility staff were noted to be consistent with facility documentation. Facility and hospice documentation was reviewed for dates [DATE] to [DATE]. On [DATE], Resident #1 had a bruise on the left forehead that was reported by CNA #1 after she gave the resident a shower. No other injuries were noted at that time. Facility staff reported that the bruise was not seen before the shower. CNA #1 denied any incident while in the shower. The facility's director of nursing (DON) notified the hospice DON of the bruise after the DON and registered nurse (RN) #1 saw the resident's hematoma and noted that it was visibly growing. -Hospice documentation stated there was a fall on [DATE]. The facility was not notified of the fall. The fall documentation was found after the facility requested hospice documentation and began the investigation on [DATE]. On [DATE], the staff reported that Resident #1 sustained a fall. She was found sitting in her room on the floor. Interventions were to review the resident's medications and check her neurological status every 15 minutes for 72 hours. Hospice staff increased her pain medication. On [DATE], Resident #1 had bruising to the left shoulder, hip and a yellow, faded bruise to the left eye. The injuries were being attributed to the fall on [DATE]. On [DATE], a nurse practitioner note (NP) stated the resident had bruising to the left shoulder. -No reported abnormality to the clavicle was noted. -Hospice documentation did not report any abnormality with the resident's clavicle until after the facility documented it on [DATE]. On [DATE], the facility requested interviews with hospice staff and they were never received. The facility was unable to identify the cause of the clavicle fracture after camera footage was obtained. The facility attributed it to either the alleged fall on [DATE] that was reported by CNA #1 (but not reported to the facility) or the documented fall on [DATE]. All documentation and facility staff interviews indicated that if the fracture was sustained on [DATE] or [DATE], it was not known to the facility or hospice staff until it was displaced and noticed on [DATE] (when the skin assessment was performed). B. Identification of others The facility terminated their contract with the hospice company on [DATE] and there had been no additional residents using that company. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility made an update to their post-fall management procedures, which included documentation in a root cause analysis form which helped identify causes and potential preventive measures for future falls. C. Systemic changes The NHA sent an email on [DATE] at 12:16 p.m. that documented that all risk management (incident reports) were reviewed daily in the interdisciplinary team meetings. He said that completion of all required assessments after a fall were part of the review process. D. Monitoring The incident was brought to the facility quality assurance and process improvement (QAPI) meeting on [DATE] and involved discussion of the investigation, the findings and actions taken. Falls were reviewed monthly at QAPI and ongoing review of all risk management/incident reports was conducted. III. Facility policy and procedure The Integrated Fall Management policy, undated, was provided by the DON on [DATE] at approximately 5:36 p.m. It read in pertinent part, Purpose: fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. Post Fall Procedure: When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. The environment of the fall is evaluated for possible contributing factors and addressed. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. Documentation of the above items is completed. IV. Resident #1 A. Resident status Resident #1, age 76, was admitted to the facility on [DATE] and expired on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included bladder cancer and Alzheimer's disease. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The [DATE] staff assessment for mental status revealed the resident had short term and long term memory deficits and was severely impaired in making daily decisions. Resident #1 did not use any assistive devices for walking. The resident required partial/moderate assistance with dressing and personal hygiene, supervision or touch assist with shower transfers, and set-up/clean-up assistance for bathing and showering. The MDS assessment indicated she had had one fall with no injury since the last assessment. assessment. B. Record review On [DATE] (before the unknown incident), a weekly skin assessment documented that Resident #1 had no skin issues. On [DATE] a progress note revealed that the bruise to the resident's head was reviewed in the interdisciplinary team (IDT) meeting and that the facility continued to monitor the resident's neurological status. The note indicated a skin evaluation was still to be done. -However, a review of the resident's electronic medical record (EMR) did not include documentation indicating how the bruise to the resident's head occurred. On [DATE] at 3:47 p.m. a post-fall assessment revealed the resident had an old bruise on the left forehead that was fading. On [DATE] at 5:45 p.m. a weekly skin assessment revealed there were no skin issues. -However, this documentation conflicted with the earlier assessment on [DATE]. On [DATE] a progress note revealed that the resident had a faded yellow bruising to the left shoulder, hip and a yellow, faded bruise to the left eye. -However, a review of the resident's EMR did not include documentation indicating how the bruise to the resident's shoulder, hip or left eye occurred. On [DATE] at 11:27 a.m. a weekly skin assessment revealed a green/yellow bruise to the left side of the resident's face, shoulder and breast. An abnormality to the clavicle was noted. The assessment documented the resident's clavicle abnormality was not reported from the previous nurse. The resident's unwitnessed fall last week was reported. Resident #1's social services care plan, initiated [DATE], revealed the resident was a vulnerable adult due to loss of independence and cognition, visual impairment, depression and anxiety, was hard of hearing, received hospice services, had poor impulse control, wandered and was difficult to redirect at times and frequently refused medication. Interventions included administering medications as ordered, providing ancillary services as needed, monitoring and reporting any new changes to the provider and utilizing approaches that maximize her involvement in daily decision making and activity. (continued on next page)

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