

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 02/24/2025
NAME OF PROVIDER OR SUPPLIER Mountain Vista Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690</p> <p>Based on record review and interviews, the facility failed to investigate an allegation of physical abuse for two (#10 and #11) of six residents reviewed out of 11 sample residents.</p> <p>Specifically, the facility failed to thoroughly investigate alleged abuse between Resident #10 and Resident #11.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy, dated October 2024, was provided by the director of nursing (DON) on 2/25/25 at 1:48 p.m. via email. It read in pertinent part,</p> <p>Abuse is defined as the willful infliction of injury with resulting physical harm, pain or mental anguish, which can include resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.</p> <p>Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking.</p> <p>Alleged violation is a situation or occurrence that is observed or reported by staff, residents, relatives, visitors or others but has not yet been investigated and, if verified, could be indication of noncompliance with the federal requirements related to abuse.</p> <p>The facility will develop and implement written policies and procedures that establish policies and procedures to investigate any such allegations.</p> <p>An immediate investigation is warranted when suspicion, or reports, of abuse occur.</p> <p>Written procedures for investigations include identifying staff responsible for the investigation, identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, focusing the investigation on determining if the abuse occurred, the extent, and cause and providing complete and thorough documentation of the investigation.</p> <p>II. Resident #10 - assailant</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A. Resident status</p> <p>Resident #10, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and dementia with behavioral disturbance.</p> <p>The 12/9/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. She required set-up/clean-up assistance for dressing, oral hygiene, and eating, and supervision for toileting and personal hygiene. She used a manual wheelchair for mobility.</p> <p>B. Record review</p> <p>A nursing progress note, dated 2/17/25, revealed Resident #10 was involved in an altercation with another resident over a pack of wet wipes. Resident #10 grabbed the other resident's hand hard and dug her nails into the resident.</p> <p>Both residents were free of harm and injury and were separated.</p> <p>An interdisciplinary team note (IDT), dated 2/19/25, revealed Resident #10 was aggravated by another resident. The other resident (Resident #11) had a pack of wet wipes and Resident #10 wanted them. The other resident (Resident #11) pulled away and Resident #10 grabbed her arm, digging her nails into her arm. Staff immediately removed Resident #10 and kept the two residents separated for several hours.</p> <p>-The 2/17/25 nursing progress note, the 2/19/25 IDT note and the facility investigation revealed conflicting information regarding the incident, whether it was the resident's hand versus her arm that was grabbed (see facility investigation below).</p> <p>III. Resident #11 - victim</p> <p>A. Resident status</p> <p>Resident #11, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease and dementia with behavioral disturbance.</p> <p>The 2/3/25 MDS assessment revealed the resident had short term and long term memory problems and had severely impaired cognition and decision-making skills per staff assessment. She required substantial assistance from staff for most activities of daily living (ADL), set-up/clean-up assistance with eating and moderate assistance with toileting. She used a manual wheelchair for mobility.</p> <p>B. Record review</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note, dated 2/17/25, revealed Resident #11 was in a resident to resident altercation that afternoon (2/17/25). Resident #11 had a pack of wet wipes that another resident (Resident #10) wanted. Resident #11 did not give up the wipes, so the other resident (Resident #10) grabbed Resident #11's arm and dug her fingernails into her arm. The two residents were okay and separated. There were no new skin issues. The family and unit manager were aware of the altercation.</p> <p>-However, the investigation had revealed Resident #11's hand was grabbed (see investigation below).</p> <p>A skin check, completed on 2/19/25, revealed no new skin concerns.</p> <p>IV. Facility investigation</p> <p>The investigation of the altercation was provided by the DON on 2/20/25 at approximately 3:00 p.m.</p> <p>The investigation documented that on 2/17/25 at 2:28 p.m. Resident #10 grabbed Resident #11's hand and dug her nails into her skin. The two residents were immediately separated by certified nurse aide (CNA) #1 and were closely monitored. A skin check was performed on Resident #11 with no injuries noted. The residents' providers, resident representatives and the local police department were notified of the incident.</p> <p>Registered nurse (RN) #1, licensed practical nurse (LPN) #1 and CNA #1 were interviewed.</p> <p>-The facility was unable to provide documentation of interviews with other residents who may have witnessed the altercation.</p> <p>The conclusion of the investigation revealed that Resident #10 and Resident #11 were friends who socialized often.</p> <p>The altercation occurred because both residents were cognitively impaired and could not verbalize their needs.</p> <p>D. Staff interviews</p> <p>CNA #1 was interviewed on 2/24/25 at 4:20 p.m. CNA #1 said she was in the dining room near the residents when the altercation occurred. She said she was talking to other residents when she heard Resident #11 yell, No! CNA #1 looked over to see Resident #10 had grabbed Resident #11's left arm. She said afterwards, the two residents were separated. She said Resident #10 was agitated and said, that was horrible. CNA #1 said Resident #10 rarely got agitated and she had never seen her do anything like that before. She said she thought Resident #11's yelling triggered Resident #10.</p> <p>RN #1 was interviewed by phone on 2/24/25 at 5:04 p.m. RN #1 said she saw video footage of the altercation. She said Resident #10 was originally at another table. She said a resident was shaking Resident #10's wheelchair wheels and agitating her. She said Resident #10 was then moved to a table with her friend, Resident #11. RN #1 said she thought because Resident #10 was already agitated, she lashed out and grabbed Resident #11's right arm.</p> <p>-However, the investigation revealed Resident #11's hand was grabbed, while the 2//17/25 nursing progress revealed the resident's arm was grabbed.</p> <p>(continued on next page)</p>		

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