STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observation, record review and interviews, the facility failed to promote dignity and respect for one (#12) of three residents out of 14 total sample residents. Specifically, the facility failed to promote dignity and respect by sitting with the Resident #12 at the dining table and providing meal assistance in a dignified manner. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL's) policy and procedure, dated 2024, was provided by the corporate nurse consultant (CNC) on 3/25/25 at 12:28 p.m. It read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: eating to include meals and snacks . II. Resident #12 A. Resident status Resident #12, over the age of 65, admitted [DATE]. According to the March 2025, computerized physician orders (CPO), diagnosis included dementia with behavioral disturbance, protein-calorie malnutrition and bilateral cataracts. According to the 1/18/25 minimum data set (MDS) assessment, the resident was severely cognitively impaired and was unable to participate in the brief interview for the mental status (BIMS) assessment. Staff reported the resident had short and long-term memory problems with severely impaired daily decision-making skills and required daily cuing and supervision to make sound decisions. The resident was able to express her needs and had some ability to understand basic conversations. The MDS assessment indicated the resident needed set-up assistance. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the resident's medical record revealed the resident needed assistance with meals (see record review below). B. Observations During a continuous observation on 3/19/25, from 11:25 a.m. to 12:24 p.m., Resident #12 was observed at the lunch counter on the unit. The resident was served lunch and had eaten some of her meat but had not eaten anything else. Resident #12 sat not eating her meal for 45 minutes before certified nurse aide (CNA) #3 approached Resident #12 initially to pick up her tray. Without talking with the resident, CNA #3 started to spoon-feed the resident in a rushed manner. CNA #3 was standing in front of the resident and not talking to the resident as she assisted her to eat. After assisting the resident with a couple of bites of food, she called over CNA #4 to finish feeding the resident. CNA #4 approached the resident and sat beside her to finish feeding her. During a continuous observation on 3/20/25, from 11:15 a.m. to 11:43 p.m., Resident #12 was observed during lunch. CNA #3 approached Resident #12 from the front and started to spoon feed her in the same rushed manner as during the observation the day prior (see above). 3. Record review The resident's nutrition care plan, initiated 10/5/21, indicated the resident had a potential nutrition deficiency. Pertinent interventions included: continuing to encourage food and fluid for comfort, honoring the resident's food preferences, providing cueing and supervision during meal service (up to maximum assist on occasion), maintaining eye contact when assisting with meals, offering the resident utensils for self-feeding and offering the resident a meal alternative if she was not eating and informing the kitchen of what she wanted. The physician's assistant (PA) note, dated 2/26/25, documented: continue to assist Resident #12 with eating assistance and nutrition, as needed. The nutrition assessment, dated 1/15/25, documented Resident #12 was eating her meals in the assisted dining room with moderate to maximum assistance and was occasionally independent. The resident had weight gain over the last two quarters despite remaining underweight. Although the weight loss was not desirable, measures to combat weight loss in hospice residents might be ineffective. The staff continued to encourage foods and fluids as the resident desired for comfort. III. Staff interviews CNA #3 was interviewed on 3/20/25 at 11:22 a.m. CNA #3 said they delivered Resident #12's meal to her and let her eat as much independently as she was able. CNA #3 said once the staff noticed the resident stopped eating, they offered verbal prompts and then offered feeding assistance. CNA #3 said the staff should sit at the table with the resident and engage her in conversation about her meal to encourage food and drink intake. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 3/24/25 at approximatly 5:00 p.m. LPN #2 said when a resident needed feeding assistance, the staff needed to sit with them and encourage the resident to eat as much as possible independently. LPN #1 said the staff increased the level of assistance as needed so that the resident would get enough to eat. The director of nursing (DON) was interviewed on 3/20/25 at 3:55 p.m. The DON said staff should sit and communicate with the resident while assisting them to eat their meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to report alleged violations of potential abuse, neglect, exploitation or mistreatment and injuries of unknown origin to the state oversight agency in accordance with state laws for two of five alleged abuse violations. Specifically, the facility failed to: -Timely report an allegation of sexual abuse by Resident #6 towards Resident #4, Resident #5, Resident #2 and Resident #3 to the State Agency; and, -Report Resident #7's injury of unknown origin to the State Agency. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation policy and procedure, dated October 2024, was received from the director of nursing (DON) on 3/19/25 at 12:45 p.m. It read in pertinent part, Abuse is defined as the willful infliction of injury with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. 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 an indication of noncompliance with the federal requirements related to abuse. Possible indicators of abuse include but are not limited to physical injury of a resident of unknown source. Sexual abuse is a non-consensual sexual contact of any type with a resident. The facility will develop and implement written policies and procedures that establish policies and procedures to investigate any such allegations. An immediate investigation is warranted when suspicion, or reports, of abuse occur. Reporting of all alleged violations to the administrator, State Agency, adult protective services and to all other required agencies within the specified timeframes. If the event that caused the allegation involves abuse or resulted in serious bodily injury or no later, report within two hours. If the event that caused the allegation does not involve abuse or result in serious bodily injury, report within 24 hours. II. Allegation of sexual abuse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Facility investigation of sexual abuse on 2/23/25 The investigation report revealed the date of the incident was 2/23/25. The incident report documented on 2/24/25 at 6:30 a.m. a certified nurse aide (CNA) reported to the unit manager that Resident #6 exposed his genitals on two different occasions to several residents. Video footage was reviewed and confirmed his indecent exposure on three separate occasions. The incidents were on 2/21/25 at 6:52 p.m., on 2/23/25 at 11:26 a.m. and on 2/23/25 at 11:34 a.m. The alleged incident happened on 2/23/25 at 11:26 a.m, on the east unit in the kitchenette area, where he exposed his genitals to two female residents (Resident #4 and Resident #5). The second incident happened immediately after the first incident on 2/23/25, at 11:34 a.m. Resident #6 wheeled himself to the main dining room. He sat at the same table as two female residents (Resident #2 and Resident #3). He touched Resident #2's arm and then proceeded to expose his genitals. Resident #2 turned her head away from Resident #6. During the facility's investigation, the facility reviewed additional video footage. The facility reported on 2/21/25 at 6:52 p.m. Resident #2 sat at a table in the main dining room alone. Resident #6 wheeled himself to Resident #2's table. Resident #6 lifted his shirt and pulled his pants down. He made motions as if he was fondling himself in front of Resident #2. Resident #6 took Resident #2's hand and tried to place her hand in his genital region. Resident #2 pulled her hand back and Resident #6 grabbed her hand again and made a fondling movement with their hands together. The behavior was repeated several times for over 20 minutes. On two occasions, Resident #6 made motions to his mouth, then to Resident #2's mouth, and then Resident #6 pointed to his genitals in a manner indicating he wanted her to perform oral sex. -The facility did not report the incident until 2/24/25 at 6:53 p.m., which was over 24 hours after Resident #6 exposed his genitals to Resident #4, Resident #5, Resident #3 and Resident #2. B. Resident #6 - assailant 1. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included alcoholic cirrhosis of the liver with ascites (chronic liver disease caused by alcohol and fluid accumulates in the abdominal cavity), dementia, psychotic disturbance, mood disturbance and anxiety. The 2/14/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) assessment score of 12 out of 15. He was independent in eating, oral hygiene, toileting, showering and dressing. He used a manual wheelchair. C. Resident #4, Resident #5, Resident #2 and Resident #3 - victims 1. Resident #4 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included atherosclerotic heart disease, hypertension, contracture of muscle and peripheral vascular disease. The 1/12/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. 2. Resident #5 Resident #5, age 72, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included Alzheimer's disease, anxiety disorder, mood disturbance and anxiety disorder. The 1/12/25 MDS assessment revealed a BIMS assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. 3. Resident #2 Resident #2, age 88, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included dementia, psychotic disturbance, mood disturbance and anxiety. The 3/3/25 MDS assessment revealed a BIMS assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. 4. Resident #3 Resident #3, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included dementia, psychotic disturbance, anxiety disorder and mood disturbance. The 1/4/25 MDS assessment revealed the resident was cognitively impaired with a BIMS score of three out of 15. III. Injury of unknown origin A. Resident #7 B. Resident status Resident #7, age 85, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included Alzheimer's disease, dementia with agitation, transient ischemic attack (small stroke), cerebral vascular disease (stroke) and depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/30/24 MDS assessment revealed a BIMS assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. She required maximum assistance with personal hygiene and showering. C. Resident's representative interview Resident #7's representative was interviewed on 3/20/25 at 11:09 a.m. The representative said he visited the resident frequently. He said when he visited Resident #7 on 3/1/25 he noticed her hand was swollen when he tried to hold her hand and she said ow. He said when he noticed her hand, he told the nurse to ask the doctor to take a look at her left hand. He said an x-ray was completed and she had a crack (fracture) in her hand. He said Resident #7 moved frequently throughout the unit in her wheelchair. He said she probably got her hand stuck in between the handrail and wall because he had seen her do that in the past. He said the facility did not say what they did to prevent the injury from happening again. B. Facility investigation of injury of unknown origin The investigation report revealed the date of the incident was 3/5/25. The investigation documented Resident #7 had a fracture of the third metacarpal (the third bone of the hand) on the left hand. The investigation documented that CNA #1 reported the resident went to bed between 7:30 p.m. or 8:00 p.m. CNA #1 said she checked on the resident at 9:00 p.m. because she heard a disturbance. The resident was sitting on the edge of the bed, trying to get out of bed. The resident's bedding was on the floor, the resident took off her brief and was in emotional distress. The investigation included the 3/7/25 provider progress note which revealed Resident #7 had edema to her fingers and the left dorsal (the back) aspect of hand. The x-ray on 3/5/25 revealed the resident had an acute (new) fracture involving the left third metacarpal with mild displacement. The resident was able to bend her finger and used her hand at baseline. She denied pain. The note documented options were discussed with the resident's representative, such as, buddy taping the fingers, an orthopedic consult, elevation and ice. The representative was understanding of the resident's dementia and her goals of care. The representative wished for comfort treatment only at that time and to continue to monitor. The investigation documented, based on the interviews the nurse manager had with the staff and based on the resident's impulsive movement, it was deemed that the fracture happened due to the resident hitting the wall or bed in her room, flailing her arms or any other type of sudden impulsive movement. -The facility was unable to provide documentation that the incident of unknown origin was reported to the State Agency. IV. Staff interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/20/25 at 3:57 p.m. The DON said she was the acting abuse coordinator. She said she did not know Resident #7's representative told the unit nurse about the swelling on 3/1/25. She said she did not know the nurse on 3/2/25 noticed swelling on Resident #7's left hand and the nurse did not report the swelling promptly. The DON said the nurse should have followed the injury of unknown source protocol. The DON said the protocol included completing a skin assessment, asking the other staff on the unit what happened and notifying the physician, abuse coordinator and the family. The DON said she did not report the injury because the resident had a history of hitting the walls. Licensed practical nurse (LPN) #2 was interviewed on 3/24/25 at 6:02 p.m. LPN #2 said if a resident had an injury, he would assess the injury and talk with the resident and staff to determine what happened. He said he would report the injury to the resident's physician and the nurse supervisor for further assessment and treatment recommendations. He said if the cause of the injury could be determined, it would be reported to facility leadership for an immediate investigation. LPN #2 said incidents involving abuse were to be reported immediately to the nursing home administrator (NHA) and the DON for investigation. He said if he observed an allegation of abuse, he was responsible for implementing an immediate intervention to protect the resident from further harm. The interim nursing home administrator (INHA) and the clinical nurse consultant (CNC) were interviewed together on 3/24/25 at 5:10 p.m. The INHA said she was the abuse coordinator as of today (3/24/25). She said the staff had two hours to report possible abuse to the abuse coordinator. The INHA said if a resident had an injury of unknown origin, the injury should be reported as possible abuse. She said when there was an injury of unknown origin, a risk management incident was completed, to include an investigation of interviewing staff, residents and family. The CNC said the nurse who noticed the swelling on 3/2/25 should have notified the physician and the abuse coordinator on 3/2/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure one (#1) of two residents out of five sample residents received treatment and care for optimal skin condition of a pressure wound and injury of unknown origin, in accordance with professional standards of practice. Specifically, the facility failed to: -Develop a care plan for treating Resident #1's moisture-associated skin damage (MASD) and preventing pressure injury due to immobility; -Reassess alternative methods of providing Resident #1's pressure-relieving interventions when the resident refused offers to be repositioned; and, -Reassess treatment methods and implement alternative interventions when Resident #1 developed a skin tear and his MASD worsened. Findings include: I. Professional reference According to Wound UK, volume 13, Number 4, 2019, Back to Basics: Understanding Moisture-Associated Skin Damage, retrieved online 4/4/25 from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.wwic.[NAME]/uploads/files/documents/Professionals/New%20Articles/MASD.pdf Moisture-associated skin damage (MASD) is the umbrella term for four clinical manifestations, namely incontinence-associated dermatitis (IAD), intertriginous (skin folds) dermatitis (ITD), periwound moisture-associated dermatitis and peristomal moisture-associated dermatitis. Excess moisture and the associated chemical irritants cause MASD. The difference between the four conditions is the type of moisture that induces the skin damage. Urine and faeces cause IAD, and ITD is caused by perspiration. IAD is a form of contact dermatitis. The substances responsible for causing IAD are urine and/or feces. Feces contain enzymes that damage the stratum corneum (outer layer of skin). Liquid feces causes more damage than solid feces as the enzymes are more destructive in the liquid form. The enzymes in feces also exacerbate the effects of urine on the skin, hence, incontinence of urine and feces is more damaging to the skin than either type of incontinence on its own. Skin damage is normally found in the perianal area, although it can extend further depending on the degree of the incontinence and speed with which the contaminants are removed from the skin. According to the All [NAME] Tissue Viability Nurse Forum, Best Practice Statement on the Prevention and Management of Moisture Lesions, September 2023, retrieved online 4/4/25 from:chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.wwic.[NAME]/uploads/files/documents/Professionals/Clinical%20Partners/AWTVNF/All_Wales-Moisture_Lesions_final_final.pdf (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To address the issues associated with the development of moisture lesions and the unacceptable consequence of inadequate continence care, the individual's skin and continence status should be assessed regularly. Early recognition and use of appropriate interventions can prevent moisture lesions from occurring in the first place. Skin should be cleansed after each episode of incontinence using pH-friendly skin cleaners and avoiding traditional soap and water, which can strip the skin. A barrier product should be used to protect vulnerable skin from contact with urine and feces. Appropriate devices to divert incontinence should be considered in patients at high risk of developing moisture lesions. Although the treatment for pressure ulcers and moisture lesions is different, patients with moisture-associated skin damage still require pressure relief. This is because the presence of moisture increases the risk of pressure damage occurring. Individuals with incontinence may also have problems with mobility and, as a result, be at risk of developing pressure ulcers as well as moisture lesions. Consequently, when inspecting an individual's skin, it may be difficult to tell if the damage to the skin is caused by moisture alone or moisture in combination with pressure. If the skin is subjected to moisture and pressure, then the treatment strategy will have to overcome both of these insults to the skin. Therefore, along with guidance on how to prevent and manage moisture on the skin, pressure relief will be an important part of care for the individual. Repositioning together with the use of pressure-relieving equipment are the main methods of preventing pressure damage caused by extended periods of localized pressure on the skin. The use of repositioning should be considered in all at-risk individuals as a prevention strategy and should be undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body. The repositioning schedule should take into account the daily activities of the individual, their ability to tolerate pressure when in the seated and lying positions and the support surfaces in use. If a moisture lesion does not respond to interventions to minimize the effects of moisture alone, then the clinician should consider whether pressure is contributing to the damage and introduce repositioning and pressure relief into the individual's care. II. Facility policy and procedure The Pressure Injury Prevention Guidelines policy, dated 2024, was provided by the corporate nurse consultant (CNC) on 3/25/25 at 1:00 p.m. It read in pertinent part, To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). The goal and preferences of the resident and/or authorized representative will be included in the plan of care. The Skin Assessment policy, dated 2024, was provided by the CNC on 3/25/25 at 1:00 p.m. It read in pertinent part, A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #1 A. Resident status Resident #1, age 72, was admitted on [DATE] and discharged [DATE]. According to the February 2025 computerized physician's orders (CPO) diagnosis included Parkinson's disease (a disease that causes tremors), diabetes and protein deficiency. The 2/2/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed substantial to maximal assistance with bed mobility (helper does more than half the effort; and the helper lifts or holds the trunk or limbs and provides more than half the effort). The resident was dependent on staff for all transfers and position changes. The MDS assessment documented that the resident did not have any pressure injury and was not at risk for pressure injury. -However, the resident's electronic medical record (EMR) documented that the resident had MASD upon admission. B. Resident#1's representative interview Resident #1's representative was interviewed on 3/13/25 at approximately 10:00 a.m. The representative said Resident #1 did not have any open pressure injuries upon admission to the facility, but soon after admission, developed an open pressure wound that continued to worsen. The resident's representative said she did not believe that the facility was treating the resident's pressure injury properly and removed the resident from the facility after suspecting that the wound had become infected. The representative said she had the resident sent to the hospital, where the resident received treatment for a stage 3 pressure wound with a suspected infection. C. Record review The resident's comprehensive care plan initiated 1/28/25 failed to document a care focus for treating the resident MASD or potential for pressure injury. Hospital discharge records, dated 1/28/25 and the 1/28/25 facility admission assessment, documented that the resident was admitted to the facility with MASD to the coccyx (base of the tailbone). The admission assessment, dated 1/28/25, revealed that the facility nursing staff assessed the resident's wound within hours of the resident's admission. The MASD measured 11 centimeters (cm) by 10 cm with no measurable depth. The wound was reddened with no open areas. The resident needed assistance with frequent repositioning as well and a pressure-reducing device was placed on the resident's bed and wheelchair. The initial skin assessment, dated 1/29/25, the resident's skin was reassessed within 24 hours of the first assessment by nursing. The nurse documented the resident had MASD on the lower coccyx region with no changes in measurement or condition. The nursing staff continued to monitor, assess and treat the resident's MASD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The skin evaluation note, dated 2/4/25, revealed the resident was assessed for a new skin issue. The nursing staff documentation revealed the resident had a skin tear with no skin loss on the coccyx at the site where MASD existed. There was no sign of infection; however, the resident expressed he had burning pain at the wound site. The note documented the resident had redness to the coccyx and a skin tear down the medial aspect of the intergluteal cleft (the groove between the buttocks). Up to this time, the resident's MASD was being treated with barrier cream and he was being encouraged to participate in frequent turning and repositioning. -There was no assessed measurement for the initial discovery of the resident's skin tear and no indication of what might have caused the skin tear. The nurse practitioner's note, dated 2/6/25, documented the resident was seen for new skin breakdown that was observed as excoriation with a small open area to the coccyx. The note revealed the resident had been refusing to turn and reposition and said it was too hard to be on him due to his Parkinson's diagnosis. The nurse practitioner recommended that the facility consider providing the resident an air mattress to help offload pressure on the resident's coccyx area. The wound care note, dated 2/6/25, documented the resident presented for a follow-up for their wound and an evaluation of MASD on the sacrum/coccyx. The note documented modifying factors included aging and impaired mobility. The MASD wound measured 2.5 cm in length by 0.3 cm in width with no measurable depth. The resident had no pain at the time of the exam. The wound bed had 100% epithelialization (development of new tissue). The periwound (skin surrounding the wound) skin texture was normal. The periwound skin moisture and color were normal. The 2/6/25 wound note also documented the resident's wheelchair cushion was evaluated and the treatment orders provided included: Cleanse and protect the wound; apply Triad cream twice a day (specialized wound care ointment to promote healing); monitor for signs and symptoms of infection; apply moisturizing cream twice a day for dry skin; and provide calorie and protein supplements per registered dietician, as needed to promote wound healing. -The wound care note failed to show evidence that the physician assessed the appropriateness of the resident's mattress for proper pressure relief. The skin evaluation note, dated 2/7/25, documented that the resident's wounds had not been assessed but included measurements of the resident's coccyx wound being 11 cm by 10 cm with no depth and no pain. -These measurements were inconsistent with the wound care specialist note dated 2/6/25 as well as the nurse practitioner notes dated 2/6/25 which revealed they had assessed the resident wound with different results (see above) The nurse practitioner's note, dated 2/7/25, documented the resident was seen in bed. The NP observed the excoriation and the resident had a small open area on the coccyx area. Barrier cream (Triad) was applied to the area. The resident had requested lidocaine ointment (a topical pain relief medication) for gluteal breakdown pain. A new order was entered for lidocaine topical cream -apply a small amount to the affected area once a day for pain to the superior gluteal fold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note, dated 2/9/25, documented lidocaine 2% external gel was applied to the coccyx for pain at the site of skin breakdown. The CNA alerted the nurse that the coccyx and buttocks seemed to have increased redness. A skin assessment was done. It was suspected that the resident had an adverse reaction to lidocaine. It was reported to the on-call provider and the lidocaine was discontinued. The nurse practitioner note, dated 2/12/25, documented the resident was assessed for skin breakdown. The resident continued to refuse repositioning but was encouraged to reposition. The resident now has an alternating pressure mattress for coccyx excoriation/breakdown. The note documented the resident had skin breakdown to the gluteal fold with peripheral erythema upon admission, however the breakdown had worsened related to the skin's continued exposure to moisture. It was recommended for the wound care team to evaluate. Nursing was to continue to apply barrier cream to the resident wound twice a day, however the resident was resistant to being moved for skin care. -It took the facility approximately 14 days to place an alternating pressure mattress on the resident's bed despite his wound worsening and refusing turning and repositioning for pressure relief and wound care. The wound care note, dated 2/13/25, documented the resident's coccyx wound was deteriorating. It measured 3 cm length by 0.4 cm width by 0.1 cm depth with a moderate amount of serous drainage (yellowish fluid that is thicker than water). New treatment orders included daily application of calcium alginate (an absorbent dressing that preserves proper moisture level) with a bordered dressing to keep the wound protected. An alternating pressure mattress in place. The wound care note, dated 2/18/25, documented the resident's wound was not healed but was improving. The wound measured 2.0 cm length by 0.4 cm width by 0.1 cm depth. Assessment: Healing is expected to be delayed due to identified factors, including impaired mobility, inevitable effects of aging, and non-compliance. The physician note, dated 2/18/25, documented the resident's buttock/gluteal wound was assessed today, peripherally expanded, with increased central breakdown. The wound was exacerbated by the resident's urinary incontinence, refusal to allow staff to change him after incontinent episodes or provide repositioning assistance to prompt offloading of pressure points of the coccyx at the wound site. The resident said he was unable to use the urinal and could not control voiding at times. The nursing note, dated 2/22/25, documented the CNA was trying to reposition the resident on his side to offload pressure on his coccyx. The resident refused and said he did not ever need to be on his side. The nursing note, dated 2/23/25, documented the resident had a coccyx wound that did not seem to be getting better. The note documented a message was left for the on-call nursing supervisor and wound care nurse. The wound care nurse said she would follow up with the physician in the morning. The family was concerned that the resident's wound was infected and requested that the resident be transported to the hospital for further assessment. IV. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 2/24/25 at 5:35 p.m. LPN #2 said residents who were bed-bound or in bed a lot and were at risk for pressure injury should be repositioned every two hours to relieve pressure and promote healing. LPN #2 said residents who refused this type of intervention could benefit from an alternating air mattress. LPN #2 said the air mattress would continuously inflate and slightly deflate the air pressure to offload continuous pressure on one point of the body and promote some circulation throughout the body. The director of nursing (DON) was interviewed on 3/20/25 at 2:15 p.m. The DON said Resident #1 was resistant to the care that was recommended to treat his MASD, despite providing the resident education to reposition. The DON said the wound specialist and the nurse practitioner (NP) were monitoring his skin and other health needs. She said he was also being followed by therapy and nursing. The DON said the resident had a standard pressure-relieving mattress but also needed to be willing to reposition. She said, despite his refusal to reposition and accept wound care on a routine basis, the staff were expected to continue to offer him repositioning as that was most important for pressure relief and healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practical physical, mental, and psychosocial well-being for two (#7 and #14) of three residents reviewed for dementia care out of 14 sample residents. Specifically, the facility failed to develop and implement effective dementia management-focused interventions to prevent Resident #7 and Resident #14 from wandering into other residents' rooms. Findings include: I. Facility policy and procedure The Dementia Care policy and procedure, undated, was provided by the clinical nurse consultant (CNC) on 3/25/25 at 4:31 p.m It read in pertinent part, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. II. Resident #7 A. Resident status Resident #7, age 85, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with agitation, transient ischemic attack (heart attack), cerebral vascular disease (stroke) and depression. The 12/30/24 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. She required maximum assistance with personal hygiene and showering. The assessment revealed the resident wandered on one to three days during the seven day assessment look-back period. -The assessment did not reveal if the resident's wandering placed the resident at significant risk of getting to a potentially dangerous place or intruded on the privacy of others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident's representative interview Resident #7's representative was interviewed on 3/20/25 at 11:09 a.m. The representative said he visited the resident frequently. He said Resident #7 was initially on a non-secured unit at the facility. He said Resident #7 wandered into another resident's room and did not give the other resident privacy. He said the facility suggested the resident move to the secured unit because the facility was concerned the resident could leave the facility or wander into areas she did not know where she was. The representative said Resident #7 wandered in the secure unit. C. Resident observations During a continuous observation on 3/2025, beginning at 12:51 p.m. and ending at 1:46 p.m., the following observations were made: On the north side of the unit, four out of the eight residents' room doors were open. On the south side of the unit, one out of the six residents' room doors was open. At 12:51 p.m. Resident #7 was in the dining area in her wheelchair in front of a dining table. Resident #7 was surrounded by other residents who sat at the communal dining table. From 12:51 p.m. to 1:08 p.m. Resident #7 used her right hand to brush back and forth in a repetitive motion on top of the dining table. She did not have any activities to engage her. From 1:04 p.m. to 1:19 p.m., an unidentified staff member arrived at the unit. The unidentified staff member offered activities to the residents at the communal dining table. The activities included a utensil organization activity, a laundry sorting activity and a coloring activity. Each activity was offered to several residents at the communal dining table. -However, staff did not offer any of the activities to Resident #7. At 1:36 p.m., licensed practical nurse (LPN) #1 closed the open doors on the north side of the unit. During a continuous observation on 3/24/25, beginning at 10:05 a.m. and ending at 11:36 a.m., the following observations were made: On the north side of the unit, six out of the eight residents' room doors were open. On the south side of the unit, four out of the six residents' room doors were open. At 10:11 a.m. Resident #7 went into the first room on the north side of the unit. At 10:15 a.m., LPN #2 redirected Resident #7 out of the room. At 10:20 a.m., LPN #2 offered coloring to the residents sitting at the communal dining table. -However, she did not attempt to engage Resident #7 in the coloring activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 10:15 a.m. to 10:34 a.m. Resident #7 continued to wander in and out of the first room on the north side of the unit. At 10:38 a.m., LPN #2 closed the door to room [ROOM NUMBER]. At 10:46 a.m, LPN #2 asked Resident #7 if she wanted to listen to a guitarist. LPN #2 pushed Resident #7 down to the area where a guitarist was setting up to perform. At 10:54 a.m. LPN #2 and CNA #1 took Resident #7 to her room for toileting care. At 11:02 a.m. Resident #7 was taken back to listen to the guitarist. She listened to the guitarist with her eyes closed off and on. At 11:35 a.m. LPN #2 escorted Resident #7 to the communal dining table for lunch. -During the continuous observation, LPN #2 did not attempt to offer coloring to Resident #7 and did not attempt to redirect Resident #7 out of the first room on the north side of the unit after 10:15 a.m. D. Record review Review of Resident #7's wandering care plan, revised 3/21/25, revealed the resident was at risk for wandering due to dementia and anxiety. The behavior could be triggered in the afternoon after her family left the facility. Interventions included encouraging the resident to attend activities in the morning, ensuring the area was safe, addressing wandering by walking with the resident, redirecting the resident away from inappropriate areas, offering ice cream, sitting with the resident, closing the doors of other resident's rooms and administering and monitoring the effectiveness and side effects of medications ordered. The 2/15/25 nurse progress note revealed Resident #7 wandered into another resident's room and was slightly tearful and restless but she was unable to express what was distressing her. The behavior decreased after the certified nurse aide (CNA) changed her brief. The 2/16/25 nurse progress note revealed the resident was tearful and wandered up and down the unit. The resident talked to the nurse or other residents for a while. The resident sobbed but was unable to verbalize what was bothering her or how she could be helped. The resident did not have severe agitation like yesterday (2/15/25) when the resident pushed tables, ran into residents, and knocked things down. Soft redirections were mildly effective. The resident was able to sit at the table for dinner. The 2/18/25 nurse progress note revealed Resident #7 was wandering through the unit in a wheelchair very quickly. The resident cried out, showing signs and symptoms of anxiety. The resident was inconsolable, stated she was tired and refused to lie down. The resident displayed this similar pattern daily after lunch until about 2:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/21/25 nurse progress note revealed Resident #7 was wandering the unit in a wheelchair, crying, and said she needed to go to the library. The resident attempted several times to push the door open. The resident was tearful. The resident was able to be redirected for only ten minutes at a time. The resident was offered food, fluid, folding clothes and washing tables. The resident returned to being inconsolable. The 2/28/25 nurse progress note revealed the resident wandered throughout the unit in a wheelchair. The 3/1/25 nurse progress note revealed Resident #7 had a weary expression and was tearful and wandering. The resident could not explain why she was distressed. The resident did not respond to attempts to redirect or distract. The resident was allowed to wander and given tissues when weepy. When dinner arrived, the resident was able to be redirected and ate and drank well. The 3/3/25 nurse progress note revealed the resident was exit seeking and wandering in a wheelchair. The resident was inconsolable with tears, attempting to stand by herself. The resident was able to be redirected for short periods of time. The resident was changed, offered fluid and food, and one-on-one time. The interventions worked intermittently to redirect the resident but the behavior returned. The 3/7/25 nurse progress note revealed Resident #7 was tearful, worried and wandered the unit up and down the hallway in a wheelchair. The resident was able to be redirected for short periods with fluid, food and one-on-one attention. The resident was not aware of other's space, ran over other residents' feet and toes and into their wheelchairs. The 3/9/25 nurse progress note revealed the resident started restless wandering in the afternoon, which was a common behavior for the resident. The 3/14/25 nurse progress note revealed Resident #7 was kept safe when wandering by keeping doors closed and the resident within line of sight. The 3/15/25 nurse progress note revealed the resident wandered in her wheelchair with a distressed look on her face and was tearful. She was unable to coherently verbalize what was bothering her. The resident had a pattern of tearful and distressed behavior almost every day between the hours of 12:30 p.m. to 4:30 p.m. Staff was generally unable to provide comfort, distraction or redirection. Toileting would occasionally calm her behavior but not consistently. -Review of Resident #7's progress notes revealed there was no consistent documentation regarding what interventions were used and which interventions were effective when the resident's wandering was observed. The behavior monitoring and intervention task record revealed Resident #7 was known to have anxiety after her family visited. She was known to respond well to a serving of ice cream after family visits. The resident responded well to sensory activities. The resident responded well to weighted blankets around her shoulders. If the other residents' room doors were closed, Resident #7 did not wander as much and did not try to leave the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation in the behavior task record from 3/1/25 to 3/24/25 to indicate if wandering was observed, if interventions were used, and if the interventions were effective. III. Resident #14 A. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included Alzheimer's disease, dementia with agitation and anxiety disorder. The 1/4/25 MDS assessment revealed a BIMS assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long term memory problems and his cognitive skills for daily decision making were severely impaired. He required supervision for oral hygiene and moderate to substantial assistance with dressing, personal hygiene, toileting and showering The assessment revealed the resident wandered daily during the seven day assessment look-back period. -The assessment did not reveal if the resident's wandering placed the resident at significant risk of getting to a potentially dangerous place or intruded on the privacy of others. B. Resident observations During a continuous observation on 3/24/25, beginning at 10:05 a.m. and ending at 11:36 a.m., the following observations were made: On the north side of the unit, six out of the eight residents' room doors were open. On the south side of the unit, four out of the six residents' room doors were open. At 10:12 a.m. Resident #14 went into room [ROOM NUMBER]. He sat off and on the first bed and held the bed's remote control in his hand. At 10:18 a.m., Resident #14 looked through room [ROOM NUMBER]'s window and played with the vertical blinds on the window. -No staff observed Resident #14 in room [ROOM NUMBER] playing with the vertical window blinds of the bed controller. At 10:20 a.m., LPN #2 offered coloring to the residents sitting at the communal dining table. -However, LPN #2 did not attempt to redirect Resident #14 out of room [ROOM NUMBER] to participate in the coloring activity. At 10:21 a.m. Resident #14 left room [ROOM NUMBER] with one of the window blind slats in his hand (an individual strip once combined with others makes a window blind). He walked to the nurse's station and left the window blind slat at the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:33 a.m. Resident #14 walked in and out of the second-to-last room on the south side of the unit. At 10:34 a.m. Resident #14 walked in and out of room [ROOM NUMBER]. At 10:38 a.m. LPN #2 closed the door to room [ROOM NUMBER]. At 10:50 a.m. Resident #14 sat on the couch where the guitarist was setting up to perform. He sat on the couch and listened to the with his eyes closed. At 11:27 a.m. Resident #14 joined the other residents at the communal dining table for lunch. -During the continuous observation of Resident #14, LPN #2 did not attempt to offer coloring to the resident, did not redirect Resident #14 out of room [ROOM NUMBER]and did not ask Resident #14 if he wanted to listen to the guitarist. C. Record review Review of Resident #14's behavior care plan, revised 7/4/24, revealed the resident wandered. The interventions included eliciting family input for the best appropriate approaches. The 2/13/25 social services note revealed Resident #14 pushed on the door trying to leave the unit after a visitor left the unit. The resident was easily redirectable. The 2/14/25 nurse progress note revealed the resident attempted to push, pull and shove doors open on the unit to the outside hallway and outside patio. The 2/18/25 nurse progress note revealed Resident #14 pushed on doors with his hands and used his hands to push against the door. The 2/25/25 nurse progress note revealed the resident pushed and pulled on doors and was able to be redirected with snacks. The 3/3/25 nurse progress note revealed Resident #14 wandered the unit and pushed and pulled on doors. The 3/7/25 nurse progress note revealed the resident pushed and pulled on doors to the outside and was exit-seeking consistently throughout the day. The 3/11/25 nurse progress note revealed Resident #14 pushed and pulled on doors, wandered the unit and checked doors. The 3/14/25 nurse progress note revealed the resident pushed and pulled on doors, wandered to multiple doors, trying them over and over. The 3/18/25 nurse progress note revealed Resident #14 pushed and pulled on doors and wandered up and down the unit, trying each door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #14's progress notes revealed there was no consistent documentation regarding what interventions were used and which interventions were effective when the resident's wandering was observed. Review of Resident #14's behavior monitoring and intervention task record revealed the resident had wandering behaviors and had exit-seeking behaviors. -There was no documentation in the behavior task record from 3/1/25 to 3/24/25 to indicate if wandering was observed, if interventions were used and if the interventions were effective. IV. Staff interviews LPN #2 was interviewed on 3/24/25 at 2:50 p.m. LPN #2 said she worked mostly in another unit. She said if a resident wandered, she kept an eye on the resident, tried to keep the resident out of other residents' rooms and provided activities to the resident. She said it was important to have interventions for residents who wandered because it helped the residents stay out of other residents' rooms and provided the residents with a purpose. She said one intervention was keeping the resident rooms' doors closed. She said it was an intervention because it prevented one resident from going through another resident's belongings. She said residents who wandered could take another resident's belongings and the items went missing. LPN #2 said she knew if a resident was a wanderer through verbal shift change reports, looking at the resident's care plan, utilizing the Kardex (an abbreviated care plan) and reading report sheets. LPN #2 said she did not document every time a resident wandered into the unit. She said she documented if the resident went into other residents' rooms and if the resident exhibited anxiety or agitation when they wandered. She said she documented her observations as a progress note. LPN #2 said she was familiar with Resident #7. She said night shift staff reported to her that Resident #7 wandered at night and offering ice cream was an effective intervention. LPN #2 said she did not know Resident #14 very well. She said he was wandering today (3/24/25). She said he sat down and watched television after lunch and that helped him not to wander. The CNC was interviewed on 3/24/25 at 5:10 p.m. The CNC said if staff saw a resident wandering into another resident's room, the staff should redirect the resident who was wandering out of the room. She said it was important to redirect the resident because the resident did not have the right to go into another resident's room without an invitation. She said interventions for residents were person-centered and included keeping other residents' doors closed if they were in the communal area, offering activities, walking with the resident and redirecting the resident. She said interventions were important because they kept the resident from going into other residents' rooms. The CNC said nursing knew if a resident wandered during their orientation period and by looking at the resident's care plan and the Kardex. The CNC said if the resident was in the secured unit, there was a level of wandering for all residents who lived in the unit. She said staff also knew if a resident wandered by reviewing a 24-hour report and when they received a verbal report from the previous shift nurse. She said if the resident exhibited new wandering or if the resident went into another resident's room, the nurse should document it as a progress note. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNC said the interdisciplinary team (IDT) discussed residents' wandering behaviors in order to develop a person-centered intervention for residents. She said she was not familiar with Resident #7. She said she did not know the residents' room doors were left open on the secure unit, and she did not know activities were not offered to Resident #7. She said she was not familiar with Resident #14. She said the staff should have redirected Resident #14 when he was in other residents' rooms. She said the facility was working on additional dementia training in the future for the nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41032 Based on record review and interviews, the facility failed to ensure facility resources were administered in a manner that allowed its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in the facility. Specifically, the facility failed to: -Provide sufficient leadership to address and or avoid multiple concerns; -Prevent, report and fully investigate allegations of abuse timely to provide immediate protections to residents at risk of being victimized and re-victimized; -Report an injury of unknown origin in a timely manner so that an accurate timeline of events could be established and the injury could be effectively treated and monitored; and, -Implement effective interventions to prevent a female resident with severely impaired cognitive and an inability to consent to a sexual relationship from wandering into a male resident's room to watch him masturbate. Findings include: I. Abuse and neglect During the abbreviated survey from 3/19/25 to 3/24/25, it was identified that there were concerns over the timely reporting of an allegation of abuse so that the resident could be immediately protected from a repeat incident of abuse. While staff immediately separated the assailant from his victims in an incident of sexual abuse, the staff did not immediately alert facility leadership so that immediate interventions could be implemented to prevent repeated attempts of abuse by the assailant. Facility leadership were not immediately notified of the incident of sexual abuse occurring. Additionally, the staff's late notifications and failure to identify the incident of sexual abuse as a reportable incident of abuse led to delays in reporting the incident to the proper entities (facility administration, the State Agency and the local police). In this instance of sexual abuse, once the incident was reported to the local police, the resident was arrested and taken to jail for his abusive actions. Cross-reference F609: failure to report an allegation of abuse in a timely manner. II. Injury of unknown origin (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the abbreviated survey from 3/19/25 to 3/24/25, it was identified that there were concerns over the timely reporting of a discovered injury of unknown origin to Resident #7. On 3/2/25, the resident's family member reported swelling, bruising and pain to the nurse on duty. While the injury was documented in the resident's electronic medical record (EMR), the injury was not reported to facility leadership until the injury worsened three days later. There was no record that the injury was monitored for proper healing. The investigation and assessment of the injury started late; it was discovered through the assessment that the resident's fingers were found to be broken (cross-reference F609: failure to report an injury of unknown origin and F658: failure to monitor an injury per professional standards). III. Leadership efforts The facility nursing home administrator (NHA) had been out on administrative leave since 1/31/25 (seven weeks as of 3/20/25), leaving the facility without a state-licensed administrator to manage the facility's day-to-day operations, particularly the management of incident reporting and investigations. The NHA had the responsibility to lead investigations for allegations of abuse to ensure compliance with identifying potential abuse; responding to an allegation of abuse; preventing ongoing abuse; and reporting abuse to the proper authority, all in a timely manner. IV. Staff interviews The director of nursing (DON) was interviewed on 3/19/25 at 12:05 p.m. The DON said the NHA was on administrative leave and she did not know if he was coming back to his position. The DON said the corporate consultants had been providing additional guidance in his absence, but she had taken on the role of abuse incident coordinator. The DON said it was difficult to manage the role of abuse incident coordinator, with all of her other duties. The DON and the corporate nurse consult (CNC) were interviewed on 3/20/25 at 3:11 p.m. The CNC said there was not currently an interim NHA with a state license filling in in the absence of the facility's NHA; however, the corporate office was looking for an interim NHA. The CNC said in the meantime, the CNC and other corporate leadership offered the DON and facility staff support onsite and remotely. The DON said she was acting as the facility abuse coordinator in the absence of the NHA, with assistance from the unit managers and social services staff, to determine needed interventions and complete abuse investigations. The DON said she would be glad to have someone take over the role of abuse coordinator because it was a lot to manage with her clinical duties. The DON said she did not report Resident #7's injury of unknown origin because she knew the resident and even though no one witnessed the injury occur, she assumed the injury was self-inflicted. The DON said she was not well-versed in the regulatory requirements for reporting and investigating abuse and was not able to give details on all types of incidents that needed to be reported. The DON said she did not know that injuries of unknown origin needed to be reported when the source of the injury was not observed, the injury could not be explained, and the injury was suspicious because of the extent of the injury or the location of the injury. V. Follow up (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/24/2025

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility hired a full-time interim nursing home administrator (INHA) on 3/24/25. The INHA had an active State NHA license and prior experience in the industry -An interview with the INHA revealed that she and the CNC had already started training with leadership staff on the components of compliance for abuse identification, reporting, prevention and investigating.