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	12/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed to investigate and document incidents of physical abuse involving two (#2 and #3) of three residents reviewed out of eight sample residents. Specifically, the facility failed to conduct a thorough investigation of physical abuse involving Resident #3 and Resident #2. Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, dated October 2024, was provided by the nursing home administrator (NHA) on 10/8/25 at 9:52 a.m. via email. It revealed in pertinent part, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: identifying staff responsible for the investigation; investigating different types of alleged violations; 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 abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and, providing complete and thorough documentation of the investigation. Analyzing the occurrence(s) to determine why abuse, neglect, occurred, and what changes are needed to prevent further occurrences; Training of staff on changes made and demonstration of staff competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and, Identification of staff responsible for monitoring the implementation of the plan.II. Incident of physical abuse between Resident #2 and Resident #3 on 8/8/25A. Facility investigationThe 8/8/25 facility investigation documented Resident #2 and Resident #3 kicked each other while in the dining room. The investigation documented the residents were separated. The investigation documented Resident #2 had a history of aggressive behaviors with three prior incidents in the facility. The investigation documented staff and a resident witnessed the incident.-The investigation failed to document what staff were involved in the incident and failed to interview staff. The investigation documented there was no cause of the altercation discovered in the initial investigation. The investigation documented that witness statements were requested.-However, there was no documentation that indicated who the witnesses were or the statements. The investigation documented Resident #2 and Resident #3 returned to their rooms after the altercation and were placed on 15-minute checks. The final report from the facility substantiated the physical abuse.Review of the investigation did not reveal Resident #2 or Resident #3 were interviewed after the incident.B. Resident interviewResident #8 was interviewed on 10/8/25 at 12:50 p.m., who was identified as alert and oriented through facility and assessment. Resident #8 said she witnessed Resident #2 and Resident #3 kicking each other. Resident #8 said Resident #2 was the bully of the facility. Resident #8 said she was seated at the dining room table where the incident occurred at approximately 8:30 a.m. while she was waiting for breakfast. Resident #8 said someone from the dietary staff was there to help and stop the situation. Resident #8 said no one from the facility asked her what happened even though she witnessed the altercation. Resident #8 said the police did talk to her about what happened. Resident #8 said even after the police spoke with her, no one from the facility talked to her about what she saw happen. She said she would have told the administrator that Resident #2 was a bully in the facility. -However, the facility failed to interview Resident #8, who witnessed the resident-to-resident abuse on 8/8/25 (see investigation above). C. Staff interviewsThe social service director (SSD) and the social service assistant (SSA) were interviewed together on 10/8/25 at 12:20 p.m. The SSD said she was not involved with the altercation with Resident #2 and Resident #3. The SSA said she spoke with Resident #3 after the incident but she did not speak to Resident #2. The SSA said she did know that a dietary staff member separated the residents. The SSA was interviewed again on 10/8/25 at 1:30 p.m. The SSA said after further research, she determined Resident #8 witnessed the altercation on 8/8/25. The SSA said she did not interview Resident #8 after the incident as part of the investigation. Licensed practical nurse #1 was interviewed on 10/8/25 at 12:45 p.m. LPN #1 said Resident #2 and Resident #3 did not like each other. LPN #1 said the staff needed to keep an eye on them if they were in the same room to ensure the residents were not fighting. Dietary aide #1 (DA) was interviewed on 10/8/25 at 1:35 p.m. DA #1 said she worked the morning the two men (Resident #2 and Resident #3) had an altercation. DA #1 said Resident #3 liked to tease other residents in a playful manner. DA #1 said Resident #3 was teasing Resident #2 and Resident #2 began yelling shut the (obscenity) up repeatedly. She said Resident #2 came up to Resident #3 and kicked him over and over, and then both residents were kicking each other. DA #1 said she witnessed the altercation and separated the residents. DA #1 said she told both residents to stop as she pulled them apart