STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain and maintain the highest practicable mental and psychosocial wellbeing for one (#2) of three residents reviewed out of five sample residents. Specifically, the facility failed to ensure services and individualized care approaches were provided, and monitored with ongoing assessment, for Resident #2 in order to meet the emotional and psychosocial needs of the resident. Findings include: I. Resident #2 A. Resident status Resident #2, age 69, was admitted on [DATE] and discharged to another long-term care facility on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included anxiety, head injury, dementia, depression and epilepsy. The [DATE] minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status score (BIMS) of eight out of 15. He required supervision with dressing, bathing, ambulation, transfers and hygiene. The assessment indicated the resident had no behaviors. B. Record review (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's psychosocial emotional trauma care plan, initiated [DATE], revealed the resident was at risk for psychosocial and adjustment issues related to emotional distress, ineffective coping skills, and poor impulse control with a history of traumatic events, to include the sudden and expected death of his wife and recent appointment of a guardian. Interventions included attempting non-pharmacological approaches, such as music therapy, breathing exercises, talking to the resident about his feelings, meditation, aroma therapy, offering reading materials and offering behavioral and psychological services as indicated. Review of Resident #2's February 2025 CPO revealed the following physician's orders: Trazodone 50 mg (milligrams), give one tablet by mouth for insomnia one time per day, ordered [DATE]. Celexa 40 mg, give one tablet by mouth for depression one time per day, ordered [DATE] and discontinued [DATE]. Behavior tracking for antidepressant medication-monitoring for self isolation and refusing to participate in activities. Document interventions attempted: one-on-one interaction and encouraging meditation, ordered [DATE]. Write a behavior note every shift for discontinuation of Celexa and initiation of Zoloft, ordered [DATE]. Zoloft 50 mg, give one tablet by mouth for depression one time per day, ordered [DATE] and discontinued [DATE]. Sertraline (Zoloft) 100 mg, give one tablet by mouth for depression one time per day, ordered [DATE]. Counseling for depression, ordered [DATE]. Olanzapine 5 mg, give one time for aggression, ordered [DATE] and discontinued [DATE]. Olanzapine 5 mg, give one tablet by mouth for aggression one time per day, ordered [DATE]. Behavior tracking for antipsychotic medication-monitoring for verbal aggression and delusions. Document interventions attempted: redirection, removal from environment, music, and offer quiet environment, ordered [DATE]. Review of Resident #2's electronic medical record (EMR) from [DATE] through [DATE] revealed the following progress notes: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior note, dated [DATE], revealed Resident #2 displayed visible distress shortly after admission. The resident paced and approached staff with delusions and paranoia. The resident told staff his wife was killed and his house was taken from him. He demanded from staff to tell him why he was in the facility or he would call the police. The staff encouraged the resident to express his concerns and reminded him that he was safe. The nurses requested a one-on-one staff member to sit with Resident #2 but the resident's guardian was unable to find anyone to sit with the resident. The guardian spoke with the resident over the phone and the physician ordered Trazodone to help the resident sleep. The 72-hour charting note, dated [DATE], revealed Resident #2 reported visual hallucinations of a dog to the staff. The nursing note, dated [DATE] at 5:32 a.m., revealed the resident expressed paranoia when staff requested to collect a urine sample from him to test for a possible infection. The resident told staff he believed the facility was testing him for drug use. The nursing note, dated [DATE] at 11:46 a.m., revealed Resident #2 told the staff he needed to leave and did not belong in the facility. The social services note, dated [DATE], revealed the resident was moved out of the memory support unit, which was not a locked secure unit, to the general population due to no longer showing interest in exit-seeking. The nursing note, dated [DATE], revealed Resident #2 became agitated when he told the nurse he was unable to reach his wife by phone. The resident said there were thugs in his home with his wife and he needed to go save her. The nurse told him the facility was now his home and his wife was not in danger. The resident continued to pace and search for an exit. The resident located an exit and threatened bodily harm to the staff if they attempted to prevent him from leaving the building. Resident #2 left the building and staff followed him until he calmed down and agreed to return. The social services note, dated [DATE], revealed Resident #2 told the social services staff he had heard from his son who informed him the resident's wife was deceased . The resident's guardian was contacted to provide comfort to the resident and to calm him down. The nursing note, dated [DATE], revealed the facility was seeking a facility with a locked secure memory care unit to move Resident #2 to. The nursing note, dated [DATE], revealed the pharmacy had to provide a week's supply of Celexa 40 for the resident until the prior authorization was complete. The nursing note, dated [DATE], revealed the physician had received the prior authorization for the Celexa but would wait to evaluate the necessity for the medication on his next visit with the resident then complete the authorization. The interdisciplinary team (IDT) note, dated [DATE], revealed Resident #2 missed nine doses of his antidepressant, Celexa. The Celexa was discontinued and Sertraline was started. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior note, dated [DATE], revealed Resident #2 attempted to leave the facility but was easily redirected. The social services note, dated [DATE], revealed the resident was accepted at another facility with a secure memory care unit. The behavior note, dated [DATE], revealed Resident #2 was packing his belongings and voicing he was going to leave that evening. The nurse was not able to redirect him. The social services note, dated [DATE], revealed the accepting facility said they could not accept the resident until [DATE]. The behavior note, dated [DATE] at 2:49 a.m., revealed Resident #2 was displaying delusions and paranoia that staff had stolen items from him. He was perseverating and hyperfixating on the delusion and was not redirectable. The resident started to believe the staff were not going to help him and he began to threaten bodily harm. The resident began to beat his chest and started to chase the nurse. The police had to be contacted to defuse the situation. The change of condition note, dated [DATE], revealed the resident was displaying new or worsening delusions and hallucinations and was a danger to himself or others. The alert note, dated [DATE], revealed the facility was seeking alternative placement for the resident. The note instructed staff to approach the resident with care when he was distressed about missing clothing. The behavior note, dated [DATE] at 6:36 a.m., revealed Resident #2 claimed to staff that someone had entered his room and stolen his wallet. Staff were unable to redirect him and the resident began pacing and yelling. The resident began throwing items in the hallway from the nurses station and then made physical threats to the staff. The resident punched the glass at the nurses station, breaking it. The staff had to contact the resident's guardian to speak with him in order for him to calm down. The behavior note, dated [DATE] at 11:04 a.m., revealed the resident was perseverating on missing items and the staff spent two hours attempting to redirect the resident. The resident became angry and hit his fist into his forehead. The resident told the staff his wallet was missing and he was worried about his wife being upset if there were fraudulent charges on his cards. After staff helped the resident search his room and the laundry for missing items and the social services staff assured him they would assist with any fraud resources, the resident was redirectable and went to activities. The social services note, dated [DATE], revealed Resident #2 was accepted for admission at a secure unit long term care facility. The resident was discharged from the facility on [DATE]. -Review of Resident #2's progress notes from [DATE] through [DATE] failed to reveal the social services director (SSD) followed up with the resident or the staff regarding the repeated behaviors or the interventions used to de-escalate the behaviors. -Review of Resident #2's EMR did not reveal any psychological and/or psychiatric behavior health provider notes or psychoactive drug meeting reviews regarding the resident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of the resident's medication administration records (MAR) and treatment administration records (TAR) from [DATE] to [DATE] did not reveal any behaviors had been documented for Resident #2. -A review of the certified nurse assistant (CNA) task documentation records failed to reveal documentation of behaviors or interventions attempted for Resident #2. IV. Staff interviews CNA #1 was interviewed on [DATE] at 12:45 p.m. CNA #1 said Resident #2 displayed behaviors of delusions, hallucinations and paranoia. She said the resident could become verbally aggressive. CNA #1 said the interventions the staff were to provide for the resident were redirection and reassurance. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:50 p.m. LPN #1 said Resident #2 was agitated when he was on the memory support unit and frequently wanted to leave. She said he could display paranoia when agitated and the staff were to provide redirection. The SSD, the social services director for the memory care unit (SSDMC), and the nursing home administrator (NHA) were interviewed together on [DATE] at 11:41 a.m. The SSDMC said Resident #2 came to the facility over the holiday break in [DATE]. She said the resident's home environment was not appropriate, as he was living alone without food, water, lights or gas. The SSDMC said the resident had a son but the son did not act as a support unit for Resident #2. She said she did not know if the resident's wife had left him or if she had died and the facility chose not to ask. She said the wife was a trigger and Resident #2 would perseverate on where she was or what was happening to her. The SSDMC said Resident #2 had behaviors of wandering and becoming more agitated as the day progressed. She said when he became more agitated in the evening, Resident #2 would become increasingly possessive of his belongings and paranoid that people were stealing from him. She said in the evening, the resident would search for his items or pack his belongings and tell the staff he was going to leave. The SSDMC said the interventions the staff would try were to help the resident search for his belongings, redirecting and contacting the resident's guardian to talk to the resident. The SSDMC said the non-pharmacological interventions for Resident #2 included redirection, calling the resident's guardian, offering music therapy, breathing exercises, meditation, aroma therapy and offering reading materials to the resident. She said the IDT determined the behavior interventions, along with input from the unit manager. She said the unit manager communicated the person-centered interventions to the floor staff. The SSDMC said the CNAs documented behaviors in the CNA tasks and the tasks were personalized by the IDT to reflect person-centered behaviors and interventions. She said the interventions the nurses used with Resident #2 came from the behavior tracking order in the resident's physician's orders. The SSD said residents taking psychoactive medications would be added to a list to be reviewed in the monthly psychoactive drug meetings, which the behavioral health providers attended. She said a new resident with a diagnosis of cognitive deficits or mental illness who was also taking psychoactive medications was reviewed within the first sixty days of admission. She said if a resident was displaying behaviors, that would warrant including the resident to be reviewed in the psychoactive drug meeting. She said the facility conducted psychoactive drug meetings every third week of the month. (continued on next page)

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