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	04/16/2025

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 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** 52513 Based on observations, record review and interviews, the facility failed to ensure one (#6) of three residents out of seven sample residents received the highest practicable treatment and care per professional standards of practice and the comprehensive person-centered care plan. Specifically, the facility failed to ensure Resident #6 received her medications in a timely manner, as prescribed. Findings include: I. Professional reference According to [NAME], P.A. and [NAME], A.G. et.al., (2021), Fundamentals of Nursing, 10 edition, pp 607-609. Medication errors can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administration of the wrong medication, giving the medication using the wrong route or time interval. Administering extra doses, and/or failing to administer medications. Preventing medication errors is essential. Professional standards such as the scope of nursing and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medication .The right medication, the right dose; the right patient; the right route; the right time; right documentation; and the right indication. Give priority to time-critical medications that must act and therefore be given at certain times. Give all routinely ordered non-time-critical medications within one hour before or after the scheduled time. According to Vallerand, A.H and Senoski, C.A. et.al., (2021), Davis's Drug Guide, 16th edition pp 605-606. When taking Gabapentin (a medication for neurological pain management), Take medication exactly as directed. Patients on three (3) times daily dosing should not exceed 12 hours between doses. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the National Library of Medicine, Medline Plus, 2025, retrieved 4/25/25, online from https://medlineplus.gov/druginfo/meds/a682530.html Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness) from multiple sclerosis, spinal cord injuries, or other spinal cord diseases. Baclofen is in a class of medications called skeletal muscle relaxants. Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord conditions. It also relieves pain and improves muscle movement. Baclofen is usually taken three (3) times a day at evenly spaced intervals. Follow the directions on your prescription label carefully. Do not take a double dose to make up for a missed one. According to Northwestern Medicine, Department of Pharmacy, Apixaban (Eliquis) September 2023 retrieved on line 4/25/25 from https://www.nm.org/-/media/northwestern/resources/patients-and-visitors/patient-education/medication/northwestern-medicine-apixaban-eliquis.pdf Apixaban (Eliquis) is a medication that prevents blood clots from forming in your blood. It is known as an anticoagulant or blood thinner. Apixaban does not actually thin the blood. It prevents new clots from forming and keeps existing clots from getting bigger and causing more serious problems. Apixaban does not dissolve clots that have already formed. It is used to prevent harmful clotting related to certain blood vessels, or heart and lung conditions. Take apixaban exactly as prescribed at the same time each day, in the morning and at night. If you miss a dose of apixaban, take it as soon as you remember, unless it is close to your next dose. This way, you do not take a double or extra dose. Then, go back to your regular dosing schedule. II. Facility policy and procedure The Administering Medications policy, revised April 2019, was provided by the nursing home administrator (NHA) on 4/16/25 at 3:45 p.m. It read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: Enhancing optimal therapeutic effect of the medication; preventing potential medication or food interactions; and honoring resident choices and preferences, consistent with his or her care plan. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: -The date and time the medication was administered; -The dosage; -The route of administration; -The injection site (if applicable); -The complaints or symptoms for which the drug was administered; -Any results achieved and when those results were observed; and, -The signature and title of the person administering the drug. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #6 A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, atrial flutter, heart failure, and atrioventricular block (blockage in the heart). The 4/11/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) score of 15 out of 15. She was dependent on staff assistance to complete most activities of daily living (ADL). B. Resident interview Resident #6 was interviewed on 4/15/25 at 2:48 p.m. Resident #6 said she was worried she was not receiving her medication at the right time. Resident #6 was not sure if it was dangerous to take the medication late or early, but sometimes she did not get her morning medications (scheduled at 7:00 a.m.) until almost noon. She said she did not remember staff telling her that there would be changes to her medication times recently. Resident #6 said she had not had any adverse reactions to the delayed medication administration times. C. Record review Review of Resident #6's April 2025 medication administration audit report (4/1/25 to 4/15/25) revealed the following: -A total of 102 medications were given late. Eighty-seven of these late medication administration events were given by licensed practical nurse (LPN) #2. On 4/7/25, 12 medications prescribed to Resident #6 were scheduled to be given between 7:00 a.m. and 10:00 a.m. All 12 medications were given at 11:27 a.m. (one hour and 27 minutes late). This included medications ordered to be given twice or three times a day. The April 2025 CPO revealed a physician's order for Baclofen oral tablet 5 milligram (mg), give one tablet by mouth three times a day for muscle spasticity of the spinal origin, ordered on 01/08/2025. -Between 4/1/25 and 4/15/25 the Baclofen was administered over an hour past the administration window 16 times. -This medication was scheduled to be given between 7:00 a.m to 10:00 a.m each morning, scheduled for 2:00 p.m. administration and to be given between 7:00 p.m. to 10:00 p.m. each day. On 4/7/25, the resident's 2:00 p.m. scheduled Baclofen was administered at 5:19 p.m. (three hours and 19 minutes late). The scheduled evening dose of Baclofen was then administered timely at 7:16 p.m., less than two hours later. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The administration of scheduled Baclofen was problematic because the resident's first and second doses were administered late and the next dose was given timely. The doses were not evenly administered to promote a consistent level of pain and spasm management (see professional reference above). The April 2025 CPO revealed a physician's order for Eliquis oral tablet 5 mg, give one tablet by mouth twice a day for the prevention of blood clots related to the diagnosis of atrial flutter, ordered 3/26/25. Between 4/1/25 and 4/15/25 the Eliquis was administered past the scheduled administration window nine times. -This medication was scheduled to be given between 7:00 a.m to 10:00 a.m each morning and to be given between 7:00 p.m. to 10:00 p.m. each day. The April 2025 CPO revealed a physician's order for Gabapentin oral capsule 300 mg, give one tablet by mouth twice a day for the treatment of neuropathic pain, ordered 3/26/25. Between 4/1/25 and 4/15/25 gabapentin was administered past the scheduled administration window nine times. -This medication was scheduled to be given between 7:00 a.m to 10:00 a.m each morning and to be given between 7:00 p.m. to 10:00 p.m. each day. On 4/11/25, all medications scheduled between 7:00 a.m. and 10:00 a.m. (13 medications) were administered at 12:19 p.m. (two hours and 19 minutes late). This included Resident #6's morning doses of Eliquis and gabapentin. -The administration of scheduled gabapentin was problematic because the resident's first dose was administered late and the next dose was given timely. The doses were not evenly administered to promote a consistent level of pain management (see professional reference above). -The administration of scheduled Eliquis was problematic because the resident's first dose was administered late and the next dose was given timely. The doses were not evenly administered as recommended in order to maintain a therapeutic level of medication to prevent blood clots (see professional reference above). IV. Staff interviews The staff development coordinator (SDC) was interviewed on 4/16/25 at 10:03 a.m. The SDC said she was working the medication cart this morning (4/16/25) due to a call off. The SDC said she had 16 residents to pass medications to this morning, including Resident #6. The SDC said the medication cart she was passing medications for used to have four more residents to pass medications for. She said starting today (4/16/25), four of the residents were moved to another medication cart on the unit because it was too difficult for the nurse assigned to this cart to finish their assigned medications on time. She said many of the residents in the hallway required two staff to reposition or provide other care, which often interrupted the medication pass because the nurse had to assist the CNAs with care tasks. The SDC said scheduled morning medications should be given from 7:00 a.m. to 10:00 a.m. unless they were time specific, like a blood sugar reading. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit manager (UM) was interviewed on 4/16/25 at 10:11 a.m. The UM said she was not sure if the residents, including Resident #6, were receiving their medication on time or not. The UM said the director of nursing (DON) recently started to review medication administration times. The UM said she decided to change the assignments for the medication carts on the unit after multiple nurses reported to her that they were having difficulty administering medications on time, given the acuity of the residents assigned to the cart. The assistant director of nursing (ADON) was interviewed on 4/16/25 at 1:15 p.m. The ADON said the facility recently implemented a change to the way medications were ordered in the medication administration record (MAR). The ADON said that scheduled medications that did not need to be given at the same time every day were ordered with a three-hour window. She said for example, a medication typically ordered at 7:00 a.m. was scheduled for 7:00 a.m. to 10:00 a.m. She said the resident was also involved in their care and may opt out of the new schedule or request medications at specific times. The DON was interviewed on 4/16/25 at 3:07 p.m. The DON said the new medication administration schedule was initiated to better accommodate the preferences of the residents while also trying to manage the workflow of the nurses. The DON said with the schedule of medications changed to a three-hour window in the MAR, she expected her staff to administer the medication in the window. She said the one-hour window on either side of the scheduled time was typical of professional standards for nurses, was included in the three-hour window; medications given after the three-hour window are late. The DON said she was not aware of how many late medication administration times occurred for Resident #6 until the audit was requested by the survey team. The DON said she spoke with LPN #2, the nurse involved with the majority of the late medications, about professional standards and timely medication administration after she saw the results of the audit. The DON said LPN #2 told her medications might have been administered earlier than the recorded time and charted on the computer later. The DON said recording routine medication administrations in the chart after administering was also not in line with professional nursing practice.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52513 Based on observations, record review and interview, the facility failed to ensure the call light system was functioning properly in its entirety. Specifically, the facility failed to ensure staff could hear the call light alerts when working in areas away from the centralized staff work area, where the call light alarm sound was heard when there were no staff in the centralized work area to hear the alarm. Findings include: I. Facility policy and procedure The Call Lights: Accessibility and Timely Response policy, revised 1/25/25, was provided by the nursing home administrator (NHA) on 4/16/25 at 3:45 p.m. It read in pertinent part: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. II. Observations On 4/15/25 at 10:56 a.m., during the walkthrough of the facility, the call light system was observed. The audible call light alarm only sounded at the nurses'station and could not be heard down the unit's hallways. A light board was located in the nurses'station with a square button for each resident room that illuminated when a resident activated the call light. Outside of the enclosed nurse's station, the activated call lights were not easily visible. There was no way to know how long the lights had been alarming or who called first. Due to the layout of the facility, the call lights were not audible down the long hallway. When standing near the nurse's station, the call lights were hard to hear due to low alarm volume Additionally, the view of the resident's overhead door call lights was obstructed from the nurses'station because the light was placed on the ceiling and the lights were obstructed by low-hanging door frames at the entrance to each hallway from the nurses station. III. Resident interviews Resident #4 was interviewed on 4/15/25 at 1:27 p.m. Resident #4 said the staff seemed to be working more than one hall at a time. She said sometimes her call light was on for up to two hours before someone can help her to the bathroom or respond when she needed pain medication. Resident #4 said she was in her room just before 3:00 p.m. when her roommate, Resident #1, began to have difficulty breathing. Resident #1 called out for help. Resident #4 said her roommate had already activated the call light and had been waiting for staff. Resident #4 said she began to blow her whistle for help just before 3:00 p.m. Resident #4 said she blew her whistle for 15 minutes before a staff member heard the whistle blowing and entered the room. Resident #4 said she knew it took an additional 15 minutes to get staff's attention because she had a clock on the wall directly across from her bed, which she watched frequently to time staff response time. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 was interviewed on 4/15/25 at 1:35 p.m. Resident #5 said she was in the facility for a short term, awaiting surgery and was frequently in pain due to her health condition. She said on several occasions she activated her call light to request pain medication and her call light was not answered timely. Resident #5 said she waited in pain for more than two hours for staff to respond to her call light. Resident #5 said she heard people in other nearby rooms calling out for help for 20 to 30 minutes at a time. Resident #2 was interviewed on 4/15/25 at 2:02 p.m. Resident #2 said she waited for 40 minutes this morning after she used her call light, waiting for staff to assist her to get cleaned up after having an incontinence episode. Resident #6 was interviewed on 4/15/25 at 2:48 p.m. until 3:42 p.m. Resident #6 said staff rarely checked on her unless she used her call light and even then, it took staff a long time to hear and answer her call light. Resident #6 expressed surprise when four staff members entered the room during the interview to check on her. Resident #6 said she could not remember exactly how long it took staff this morning to answer her call light but knew it was over an hour that she was sitting in her own urine waiting for staff to answer her call light. Resident #6 said yesterday (on 4/14/25) she was in her room eating lunch and became short of breath. When she felt her oxygen tubing she could not feel air coming out of the tubing so she pressed her call light for staff assistance. Resident #6 said staff did not respond and nobody came until she began to yell for help. IV. Record review The NHA provided documentation of the facility's internal audit of call light response times on 4/15/25 at 4:50 p.m. The facility's internal audit of call light response times that were conducted on 3/11/25 from 10:08 a.m. through 3:20 p.m. revealed a range of call light response times while staff was observed by facility administration. The times ranged from one minute at the fastest response time to one hour and 42 minutes at the slowest response time. The facility's internal audit of call light response times conducted on 3/28/25 from 8:39 a.m. through 4:36 p. m. revealed a range of call light response times while staff was observed by facility administration, ranged from one minute at the fastest response time to 25 minutes at the slowest response time. A respiratory therapist's (RT) note in Resident #1's electronic medical record (EMR), dated 2/5/25 at 3:12 p. m., documented while the RT was completing respiratory care rounds at the facility, he heard a whistling sound coming from a resident's room. No other staff were responding to the alarm and the call light was not heard. When the RT arrived to the room, Resident #1 was in need of immediate medical attention. -However, because the facility's call light system was unable to show the order in which call lights were received, and was not able to be heard in the resident hallway, there was no way for staff to respond in a timely manner and no way to know how long Resident #1 waited in distress for the staff's response. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident grievance forms from 2/3/25 through 4/7/25 revealed five resident initiated grievances were filed, documenting long call light response times with staff not responding to requests for care in a timely manner. The grievances documented a resident's were waiting over 30 minutes for incontinence care on 2/4/25 and other complaints documented long call light waits occurring on the overnight shift on 3/7/25, 3/14/25 and 4/7/25. The resident council minutes, dated 1/15/25, documented the residents had complaints that nursing staff were not providing timely care and the resident council requested the facility work on call light response times. The resident council minutes from 2/19/25 revealed there were improvements in call light response times after the start of audits by facility managers. However, the minutes report call light response times remained an issue during night shift and on weekends. V. Staff interviews A frequent visitor to the facility was interviewed on 4/15/25 at 4:37 p.m. The frequent visitor said the most frequent complaint received from residents in the facility was long call light waits. The frequent visitor was aware that the NHA was working on the concern but said the complaints remain problematic and have not been fully resolved. Certified nurse aide (CNA) #3 was interviewed on 4/16/25 at 10:22 a.m. CNA #3 said she could not hear the call light alarms when she was down the hall away from the nurse"s station and some other locations on the unit. She said she took care of residents on multiple hallways throughout her shift and often had to cover for the CNA when they left their assigned units to cover the dining room during meal times to ensure resident care needs were met. CNA #3 said it was difficult to hear the call light when down the long hallways and if she was able to hear the call light it took time to investigate who was calling because you could only see the outside door call light from certain view points in the hall. CNA #3 said staff had to go from hall to hall to see which light was on or go to the nurse's station to see whose light was on. -However, there was no way for the staff to know which resident had their light on the longest. Licensed practical nurse (LPN) #1 was interviewed on 4/16/25 at 10:30 a.m. LPN #1 said despite the staff having good teamwork, it was difficult to see some of the call lights depending on where she [NAME] on the unit. LPN #1 said the call light alarm sound only had two different tones, one for the bedside and one for the bathroom. LPN #1 said she did not know if there was any way to tell which resident called first or how long the resident had been waiting for assistance by looking at the board of call lights. CNA #1 was interviewed on 4/16/25 at 10:39. CNA #1 said the resident's call lights did not have an audible sound by the resident's room and the only way to know if they were activated was to notice the hallway door light was on. CNA #1 said there was no way to know who activated their call light first and she did her best to answer call lights as they came on in a timely manner. She said it was hard to see the activated call lights due to the low door frames placed midway down the hall. To see the call lights she had to frequently duck or squat down to see if a light was activated. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing home administrator (NHA) was interviewed on 4/16/25 at 1:15 p.m. The NHA said that the leadership team responded to resident complaints and grievances related to call light response times by completing internal audits of different units at various times and provided staff training on the expectations of answering call lights timely. The NHA said he expected call lights to be responded to within at least 30 minutes, preferably within 15 minutes. The NHA said he also educated staff on where to look to see lights in certain halls that are partially obstructed due to the layout of the building. The NHA said he was aware the technology of the call light system could use improvement and requested funding to improve the system but did not know if funding will be approved or not.