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	04/01/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#2) of three residents was kept free from physical abuse out of six sample residents.Specifically, the facility failed to protect Resident #2 from physical abuse by Resident #3.Findings include:I. Incident of physical abuse towards Resident #2 by Resident #3 on 2/9/26The facility investigation documented that on 2/9/26 at 10:05 p.m. Resident #2 reported that Resident #3 called him a homosexual slur after requesting alcohol from him. Resident #2 said he was frustrated, confronted Resident #3 and grabbed his shirt. Resident #2 said after he grabbed Resident #3's shirt, Resident #3 then made contact with Resident #2's face with an open hand. Staff members intervened and ensured both residents stayed separated. Both residents were immediately assessed by nursing staff following the incident. No injuries were observed or reported for either resident. Fifteen minute checks and psychosocial check-ins were initiated, and nursing assessments were completed. The facility reported the incident to the police, updated both residents' care plans, educated staff on resident-to-resident altercations and monitored Resident #2 and Resident #3 to ensure they remained separated from each other in common areas. II. Resident #2 (victim)A. Resident statusResident #2, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included acquired absence of left leg above knee, acquired absence of right leg above knee and neuritis (nerve inflammation).The 1/14/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was independent with transfers and toileting, and required supervision for slide board transfer to showers. The MDS assessment indicated the resident did not have any behaviors.B. Resident interviewResident #2 was interviewed on 4/2/26 at 12:46 p.m. Resident #2 said the incident with Resident #3 happened in the activities room. Resident #2 said Resident #3 was talking too much, and he told him to stop, but Resident #3 yelled at Resident #2 with racial and sexual orientation insults and hit him on his face. Resident #2 said he grabbed Resident #3's shirt, and then turned around and left. Resident #2 said he was just protecting himself during the incident, and there were no staff members present. Resident #2 said after the incident with Resident #3, the facility staff moved him to a different hallway since both residents used to live in the same hallway. He said since then, the incident, staff members had kept them separated. Resident #2 said he did not have any injuries after the incident.C. Record reviewThe trauma informed care plan, initiated 9/13/25, documented Resident #2 reported a history of trauma and life threatening illness or injury. Resident #2 became a double amputee in March 2025. Interventions included encouraging the resident to seek support as needed, offering behavioral health services as needed, educating the staff on the resident's trauma history and triggers to avoid instances of re-traumatization, mental health referrals as needed and updating the resident's trauma informed care plan as needed.The 2/10/26 progress note documented the assistant director of nursing (ADON) at approximately 10:05 p.m., revealed that Resident #2 and Resident #3 were involved in a fight in the activities room. Both residents were separated by and assessed by the ADON and licensed practical nurse (LPN) #4.III. Resident #3A. Resident status (assailant)Resident #3, age less than 65, was admitted on [DATE]. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the April 2025 CPO, diagnoses included type 2 diabetes mellitus with diabetic neuropathy, acquired absence of left leg below knee, acquired absence of right foot, phantom limb syndrome, unspecified mood (affective) disorder and depression.The 3/23/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent for transfers, bathing and most of his ADLs.The MDS assessment indicated the resident did not have any behaviors. B. Resident interviewResident #3 was interviewed on 4/1/26 at 12:59 p.m. Resident #3 said Resident #2 got out of control on 2/9/26, so he had to put him under control. Resident #3 said during the incident, there were no staff members present and no one suffered an injury. C. Record reviewThe behavior care plan, initiated 8/15/24, documented Resident #3 had a potential and history of being verbally aggressive (cursing and yelling at staff members) related to ineffective coping skills. Interventions included analyzing key times, places, circumstances, triggers, and what de-escalated the resident's behavior and documenting, assessing and anticipating the resident's needs and comfort level, monitoring behaviors, providing positive feedback for good behavior, psychiatric consult as indicated and, when the resident became agitated, intervening before the agitation escalated.The psychosocial and behavioral care plan, initiated 2/10/26 (the day after the incident with Resident #2), documented Resident #3 exhibited or was at risk for behavioral symptoms (striking out, grabbing others, being combative, verbally aggressive, and the use of derogatory words, including sexual orientation towards others, or physically abusive) due to depression, and to an unspecified mood (affective) disorder diagnosis. Interventions included assessing diversional activities, anticipating needs and meeting them promptly, documenting and recording behavioral episodes, encouraging the resident to verbalize his feelings, and establishing rapport.-Review of Resident #3's progress notes revealed no documentation of the incident between Resident #3 and Resident #2.IV. Additional resident interviewResident #6 was interviewed on 4/1/26 at 4:04 p.m. Resident #6 said she was present when the incident between Resident #2 and Resident #3 occurred (on 2/9/26). She said Resident #3 was talking too much and too loudly, and Resident #2 told him to calm down. She said Resident #3 overreacted, insulted Resident #2, and hit Resident #2 in the face. Resident #6 said there were no staff members in the activities room at the time of the incident and it took a long time for staff to come and separate them. She said by the time staff arrived in the activities room, Resident #2 had already left the room.V. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 4/1/26 at 3:32 p.m. CNA #4 said she did not hear about the incident between Resident #2 and Resident #3. However, she said that Resident #3 exhibited aggressive behavior, and staff members respected his personal space. CNA #4 said she did not hear anything about any new interventions for Resident #3's behaviors to prevent further incidents.LPN #3 was interviewed on 4/1/26 at 4:40 p.m. LPN #3 said the incident between Resident #2 and Resident #3 happened in the evening. She said the ADON told her that there was an incident between Resident #2 and Resident #3 in the activities room. LPN #3 said Resident #3 insulted and then hit Resident #2. LPN #3 said the incident was reported to management, and the staff moved Resident #2 to a different hallway, even though it was the only time both residents were involved in an incident. LPN #3 said since the incident, the staff avoided having both residents smoking outside at the same time.The director of nursing (DON), the ADON, and the regional nurse consultant were interviewed together on 4/1/26 at 5:15 p.m. The ADON said several residents were hanging out and listening to music that night (2/9/26) in the activities room. The ADON said she heard someone screaming for a nurse and went to check on the residents. The residents in the activities room reported there had been a verbal and physical altercation between Resident #2 and Resident #3. The ADON said she did not see what happened, but she went to assess both residents after the incident. The ADON said the facility initiated the following interventions after the incident: 15-minute checks, moving Resident #2 to a different hallway and keeping both of the residents separated from each other. The ADON said residents were allowed to go to the activities room at night and be there without supervision. The DON said she talked to Resident #3. The DON said Resident #3 reported that Resident #2 grabbed his shirt, so he pushed Resident #2 away. The regional (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse consultant said the incident between Resident #2 and Resident #3 was substantiated as abuse by the facility.