STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065228	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon View Care Center	151 E 3rd St Palisade, CO 81526

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent the occurrence or recurrence of pressure injuries for one (#12) of three residents reviewed out of 24 sample residents.Specifically, the facility failed to:-Ensure complete and thorough documentation of weekly wound assessments to track the progression of a chronic pressure injury for Resident #12; and,-Ensure recommendations provided by the outpatient wound clinic provider were followed for the chronic pressure injury for Resident #12. Findings include: I. Professional referenceAccording to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 2/6/26 from https://www.internatinoalguidline.com/2019 Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk).Category/Stage 2: Partial Thickness Skin LossPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.Category/Stage 3: Full Thickness Skin LossFull thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue LossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.Unstageable: Depth UnknownFull thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed.Suspected Deep Tissue Injury: Depth UnknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. Pressure injury assessment includes an evaluation of the pressure injury size and physical characteristics Assess and document physical characteristics of the pressure injury, including: Anatomical location, category/stage, size and surface area, tissue type(s), color, periwound condition, wound edges, sinus tracts, undermining and tunneling, exudate and odorII. Facility policy and procedureThe Pressure Injury Prevention and Management policy, revised February 2024, was provided by the nursing home administrator (NHA) on 2/5/26 at 11:09 a.m. It revealed in pertinent part, Weekly documentation of the pressure injury should include at least the following: Locations and stage of the pressure injury, size (perpendicular measurements of the greatest extent of length and width of the ulcerations), depth; and presence, location and extent of any undermining or tunneling/sinus tract. Please note the length assessment is always measured head to toe. Exudate, if present: type (such as purulent/serous), color, odor and approximate amount. Pain, if present: nature and frequency (e.g., whether episodic or continuous). Wound bed: Color and type of tissue/ character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar). Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate. Pressure reducing surfaces. Any changes in pressure injury condition should be reported to the physician. III. Resident #12A. Resident statusResident #12, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included paraplegia (paralysis from the waist down) pressure ulcer of the sacral region, stage four, pressure ulcer of the left buttock stage four, pressure ulcer of the left ankle stage four, pressure ulcer of the right ankle stage four, non-pressure chronic ulcer of other part of the right foot with fat layer exposed, osteomyelitis of the vertebra, sacrum and sacrococcygeal region, chronic peripheral venous insufficiency, methicillin resistant staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere.The 1/9/26 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. Resident #12 was independent with eating, upper body dressing and oral hygiene. Resident #12 required set up assistance with bathing. Resident #12 was dependent on staff for toileting, lower body dressing, footwear and personal hygiene. B. Record reviewResident #12's care plan, initiated 8/29/17 and revised 11/25/25, documented Resident #12 had multiple chronic wounds including a right lateral foot wound with a history of recurrent MRSA infections to multiple wounds. Interventions included assessing, recording, observing the wound healing weekly; measuring the length, width and depth where possible; assessing and documenting the status of the wound perimeter, wound bed and healing progress; and reporting improvements and declines to the provider.A review of Resident #12's February 2026 CPOs revealed the following physician's orders to Resident #12's right lateral foot wound: -Cleanse with wound cleanser, apply cavilon skin prep to peri wound tissue and apply a foam border dressing three times a week and as needed (PRN). -Monitor for signs and symptoms of infection. Observe for abnormalities to the wound bed, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surrounding skin, or pain associated with the wound, document any abnormalities in the nursing progress notes. Ordered 7/30/25The nursing progress note, dated 1/20/2026 at 7:18 a.m., revealed the outpatient wound clinic nurse practitioner recommended to cleanse the right lateral foot wound with wound cleanser, apply calcium alginate and dry dressing, change daily and as needed if dislodged, saturated, or soiled. The nursing progress note, dated 1/27/2026 at 2:42 p.m., revealed the outpatient wound clinic nurse practitioner recommended to cleanse the right lateral foot wound with wound cleanser, apply calcium alginate and dry dressing, change daily and as needed if dislodged, saturated, or soiled.-Review of Resident #12's January and February Treatment administration record revealed the facility failed to update the frequency of the wound care orders to daily instead of three times per week in accordance with the outpatient wound clinic nurse practitioner's recommendations. A review of Resident #12's electronic medical record (EMR) revealed missing weekly wound assessment forms for the following weeks: 10/5/25, 10/26/25, 11/2/25, 11/16/25, 11/23/25, 11/30/25, 12/21/25 and 12/28/25.IV. Staff interviewsThe director of nursing (DON), regional consultant and NHA were interviewed together on 2/5/26 at 11:09 a.m. The regional consultant said the facility underwent an internal survey on 1/12/26. The regional consultant said inconsistent wound assessment documentation was identified during the internal survey and a plan of correction was started. The DON said she completed wound care assessments including measurements each week, but did not complete assessments in the EMR because the resident also had wound care clinic appointments some weeks and she thought the outpatient provider notes were sufficient. The DON said she kept a log of each of Resident #12's wounds in a spreadsheet including measurements to monitor the progress of each wound. The regional consultant said she provided education to the DON to complete assessments in the EMR each week. The regional consultant said the facility also started an audit of all residents with wounds in the facility to find missing weekly wound assessment forms. The NHA said they asked the outpatient wound care clinic to no longer send the nurse practitioner who completed the wound care assessments in January because her measurements of multiple residents' wounds were not accurate. The DON said she reviewed the outpatient wound clinic documentation from the nurse practitioner, but she was not sure if the nurse practitioner recommended any changes to Resident #12's wound care orders. -However, a review of the plan of correction provided by the NHA on 2/5/26 at 11:09 a.m. revealed the DON did not receive verbal education on the requirement to complete weekly wound care notes until 2/4/26 (after the start of the survey). A review of the wound tracking logs provided by the DON revealed missing weekly wound assessment documentation without a corresponding outpatient wound clinic progress note for the weeks of 10/5/25 and 12/21/25. The wound tracking log provided by the DON included only measurements with no documentation of descriptions of the wound bed, periwound tissue or exudate from the wound for the weeks of 11/21/25 and 12/18/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and observations, the facility failed to ensure residents were free from accidents or hazards for one (#14) of three residents reviewed for accident hazards out of 24 sample residents. Specifically, the facility failed to prevent the elopement of Resident #14. Findings include:I. Facility policy and procedureThe Elopement and Wandering policy, initiated 2/29/24, was provided by the nursing home administrator (NHA) on 2/5/26 at 2:41 p.m. It read in pertinent part, To ensure the safety and well being of all residents with potential elopement risk. It is a goal of the facility to provide a safe environment using the least restrictive measure available in caring for residents who are exhibiting elopement behavior. Implementing and care planning interventions to address safety and decrease risk of elopement.II. Facility investigationThe facility investigation was provided by the NHA on 2/4/26 at 9:36 a.m. The facility investigation documented Resident #14 was in a locked courtyard on 11/30/25 and was last seen at 8:30 a.m. by a nurse. Resident #14 was believed to climb the metal railing over the fence and leave the facility grounds. The resident encountered a police officer at approximately 9:10 a.m. Resident #14 asked the officer to take him closer to his house. The police officer proceeded to drop off the resident at the gas station six miles away from the facility in the neighboring town. According to the investigation, on 11/30/25 at 9:15 a.m. the staff completed the breakfast meal service with the other residents on the secured unit and went outside into the courtyard to notify Resident #14 that his breakfast was ready. At that time, the staff determined the resident was not in the courtyard and initiated a full facility and perimeter search. The police were notified of the missing resident at 9:39 a.m. The police picked the resident up at the gas station and returned him to the facility at 10:14 a.m. without injury.The facility investigation documented the review of the courtyard identified there were no other access points other than proximity of a metal railing near fence that could have contributed to Resident #14's elopement. The facility removed a portion of the metal railing that was believed to have allowed access over the fence and placed the resident on one-to-one supervision while in the secured unit courtyard. III. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included unspecified dementia, mild with mood disturbance, major depressive disorder, recurrent, and personal history of Hodgkin's lymphoma.The 12/1/25 minimum data set (MDS) assessment revealed Resident #14 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He was independent with his mobility and required limited to no assistance with most of his activities of daily living. According to the MDS assessment, Resident #14 had wandering behaviors. IV. Resident interviewResident #14 was interviewed on 2/4/26 at 3:05 p.m. Resident #14 said he was very frustrated and wanted to go home. He said when he first arrived at the first he was very confused as a result of his treatment for his disease (lymphoma). He said he knew he had memory issues from his treatment but did not feel belonged at the facility and wanted to go home. He said he had left the facility before by climbing over two fences outside. V. Observation and interviewsThe facility's two facility courtyards were observed with the maintenance director (MTD) on 2/4/26 at 4:00 p.m. Review of the secured unit courtyard identified a portion of the metal pathway railing was removed and discarded in the second courtyard (smoking courtyard). The wooden fence that Resident #14 was believed to have climbed by use of the metal railing was approximately six feet high. The fence was shared with the smoking courtyard. The gate to the fence was secured with a keypad attached to an alarm which entered into the smoking courtyard. The review of the smoking courtyard identified a chain link fence surrounding the perimeter of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	courtyard. In the back of the courtyard was wired fencing between the [NAME]. The top of the wired fencing was slightly bent down. The MTD said he did not know how long the wired fencing had been bent. VI. Record reviewThe elopement care plan, revised 12/5/25, identified Resident #14 was an elopement risk related to his dementia. According to the care plan, Resident #14's triggering words for wandering/eloping were the use of the words guardian and conservator. The care plan interventions directed staff to identify a pattern of his wandering and intervene as appropriate (revised 12/5/25); providing structured activities of toileting, walking inside the facility and outside, and use of reorientation strategies (revised 2/4/26); providing a staff member with Resident #14 at all times when he was outside in the courtyard due to his risk of jumping the fence (initiated 12/5/25); distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, chocolate and juice (revised 2/4/26); and, providing the resident with de-escation behavioral strategies of redirection, moving to a quiet place, providing one-to-ones and going outside in the courtyard with staff (2/4/26).The 5/22/25 weekly nursing note documented Resident #14 frequently talked about leaving the facility and told the activities staff that he wanted to jump the fence and run. The 7/13/25 behavior note documented Resident #14 had been perseverating about his property. According to the note, he said he wanted to jump the fence and return to his property.The 11/9/25 behavior note, documented Resident #14 offered to help an activity staff member take the breakfast cart back to the kitchen off of the secured memory unit. According to the note, when the activity staff member was not looking, he quickly went to the front door and shoved and kicked it hard in an attempt to open it. The 11/26/25 nursing note documented Resident #14 was observed standing on the metal railing in the backyard (courtyard) and looking over the wooden fence into the smoker's courtyard. According to the note, the resident got down from the railing without assistance and was encouraged to not stand on the railing. The 11/28/25 behavior note documented Resident #14 was yelling that his property was stolen and said he wanted to take a bus or hitchhike home. According to the note, the staff advised the resident that the police would bring him back to the facility if he left. The 11/29/25 behavior note Resident #14 spent most of the day outside, away from other residents. According to the note, Resident #14 offered to pay a nurse $3000.00 to take him home. He told the nurse that he had to get out of the facility and go home by walking or hitchhiking. The 11/30/25 nursing progress note documented Resident #14 went over the back fence and was returned to the facility by the police. VII. Staff interviewsActivity assistant (AA) #1 was interviewed on 2/4/26 at 2:35 p.m. AA #1 said Resident #14 was upset about the loss of his property prior to his elopement. She said she tried to help the resident's mood with activities of interest. The NHA was interviewed on 2/4/26 at 4:12 p.m. The NHA said on 11/30/25, Resident #14 was picked up by a police officer approximately five blocks from the facility after he eloped and dropped off at a gas station in the neighboring town and then brought back to the facility. She said the secured unit courtyard was assessed and it was determined that the only way Resident #14 could have eloped was for him to go over the fence. She said the resident was asked about his elopement and he pointed to the fence that he went over. The NHA said there were no reports to her of him wanting to leave or attempting to leave, prior to his elopement. She said the facility was looking into trialing a room for him off of the unit, prior to his elopement. She said he had periods of calm behaviors and other times he would tell staff he wanted to go to his property. The NHA said no one reported to her that Resident #14 was standing on the metal railing a few days prior to his elopement. She said that should have been reported to her. She said if she had been made aware, then the resident would have been placed on one-to-one supervision in the courtyard and not just frequent checks when he was outside. The NHA said on the morning (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 11/30/25, Resident #14 was agitated and went outside to the secured unit courtyard to de-escalate. She said he went outside alone at approximately 8:05 a.m. or 8:10 a.m. The NHA said the staff usually would check on the resident every five to 15 minutes by glancing outside. She said the secured unit staff did not check on him that morning as frequently as they normally would because they were serving the other resident's breakfast at the time. The NHA said at 8:30 a.m., a nurse saw Resident #14 in the smoker's courtyard but the nurse was new to the facility and was not aware that he was a secured unit resident and should not be in the general population/smoker's courtyard. The NHA said since the elopement, the resident was now required to have one-to-one supervision when in the courtyard and no longer just on frequent checks. She said Resident #14 could no longer sit outside alone. The MTD was interviewed on 2/4/26 at 3:50 p.m. The MTD he was made aware of the elopement of Resident #14 and removed a section of mental pathway railing alongside of the fence in the secure unit courtyard. The MTD said no other modifications were made to the courtyard. He said the secure unit courtyard was secured at the gate by a key pad and weekly he checked the alarm of the gate to ensure it was in good working order. He said he was not asked to remove or modify the metal railing prior to the resident's elopement. The MTD said Resident #14 went over two fences to leave the property (see observation above). The NHA was interviewed on 2/5/26 at 12:18 p.m. The NHA said there was no staff education implemented after the elopement. She said she did not feel additional education was needed. She said the staff followed his care plan to allow him to cool off outside and followed the elopement policy. The NHA said Resident #14 expressing desire to leave was a pattern of his. The secured unit manager was interviewed on 2/5/26 at 1:54 p.m. The unit manager said prior to Resident #14's elopement, staff would check on him every 10 to 15 minutes when he was in the secured unit courtyard. She said there was no formal schedule to check him before he eloped. She said the staff just knew to check on him. The unit manager said the resident never indicated that he wanted to leave. She said she was not aware that the resident was observed standing on metaling railing near the fence prior to his elopement. The unit manager said the secured unit courtyard had two areas. The first area was just outside the dining room where staff could look out the window or the door and see Resident #14. She said the second area of the secured unit courtyard was along the side of the facility which could have hindered the visibility of the resident from staff. Registered nurse (RN) #1 was interviewed on 2/5/26 at 2:02 p.m. RN #1 said Resident #14 was usually in line-of-sight in the courtyard and staff would check on him every 10 to 15 minutes. She said she was working on the day he was observed standing on the metal railing by the fence (11/26/25). She said she was told he was talking to another resident on the other side of the fence and shaking someone's hand. She said she documented the incident and reported it to the next shift nurse. The NHA was interviewed again on 2/5/26 at 2:11 p.m. The NHA said the facility was discussed Resident #14 moving off the secured unit and into a less restricting environment in July 2025 and again in August 2025. She said Resident #14 decided he did not want to move off of the secured unit. The NHA said it was normal for him to say he did want to remain at the facility and he would become agitated. She said staff would allow him to cool off outside in the secured unit courtyard. She said staff would just get a quick visual confirmation when he was outside because sometimes he was not accepting of the staff to stay or sit with him prior to the elopement. The NHA said she reviewed her investigation and was reminded that it was about 40 minutes from the time the secured unit staff saw the resident and the time they discovered he was unaccounted for. She said his nurse saw him at 8:30 a.m. The NHA said the new nurse on the general population side saw him at approximately 8:45 a.m. in the smoker's courtyard. AA #2 was interviewed on 2/5/26 at 4:38 p.m. AA #2 said activity staff tried to keep an eye on all the residents during activities. (continued on next page)

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