

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	

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)
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>Based on record review and interviews, the facility failed to ensure that residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for two (#3 and #4) of three residents reviewed out of four sample residents.</p> <p>Specifically, the facility failed to identify Resident #3 and Resident #4's post traumatic stress disorder (PTSD) and identify triggers which may retraumatize them.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Trauma Informed Care policy and procedure, undated, was provided by the director of nursing (DON) on 9/4/24 at 4:38 p.m. It read in pertinent part, It is the policy of the community to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice.</p> <p>Each resident will be screened for a history of trauma upon move-in by the community's social service or designee.</p> <p>If the screening indicates that the resident has a history of trauma and/or trauma-related symptoms, an order will be obtained for the resident to be evaluated by mental health professional who is qualified and experienced in working with those exposed to trauma.</p> <p>Once the order is received, the referral to the mental health professional will be made.</p> <p>The community will account for residents' experiences, preferences, and cultural differences to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>II. Resident #3</p> <p>A. Resident status</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3, age 78, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease (COPD), post-traumatic stress disorder (PTSD) and anxiety disorder.</p> <p>The 7/9/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He was dependent on staff assistance for lower body dressing, putting on/taking off footwear, chair/bed to chair transfer, toilet transfer, tub/shower transfer, showering/bathing self and toileting hygiene.</p> <p>B. Resident interview</p> <p>Resident #3 was interviewed on 9/4/24 at 11:35 a.m. Resident #3 said he served in the Navy for four years and was an aircraft carrier in Vietnam. He said he had been diagnosed with PTSD. He said he was not receiving services for PTSD.</p> <p>C. Record review</p> <p>The feelings care plan, revised on 10/26/21, documented Resident #3 was at risk for feelings of sadness, emptiness, anxiety, uneasiness, depression, characterized by ineffective coping, low self-esteem, tearfulness, motor agitation and withdrawal from care/activities and loss of independence. Pertinent interventions included monitoring the resident's mental status and mood state changes when new medication was added and involving the resident in making his own schedule.</p> <p>The mood care plan, revised on 6/26/24, documented Resident #3 had a mood challenge related to insomnia. Interventions included monitoring and recording the resident's mood to determine if problems seem to be related to external causes, medications, treatments and or concerns over diagnosis; tracking hours of sleep and having caregivers to assist the resident/family in identifying the residents strengths, encouraging positive coping skills and reinforcing them.</p> <p>The behaviors care plan, revised on 12/27/21, documented Resident #3 had behavior challenges related to sexually inappropriate behaviors towards female staff. Interventions included providing the resident the opportunity for positive interaction and attention, stopping and talking with resident when passing by, having the nurses monitor the resident's behaviors for inappropriate sexual comments to female staff, offering and documenting non pharmacological interventions as needed , setting clear boundaries, educating on appropriate ways to speak to staff, offering snack or drink, redirecting to an activity, offering independent activity supplies for validation and providing encouragement to express feelings appropriately.</p> <p>-Review of the resident's comprehensive care plan did not reveal a care plan related to Resident #3's PTSD to include person-centered individualized interventions, personalized triggers or personalized signs and symptoms.</p> <p>The 1/3/24 social services quarterly assessment revealed Resident #3 had minimal depression. The resident self-reported little interest in doing things, depressed mood and feeling bad about himself. The assessment documented Resident #3 had PTSD and anxiety.</p> <p>-Review of Resident #3's electronic medical record (EMR) did not reveal the facility had determined what triggered Resident #3's PTSD.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>III. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age 79, was admitted on [DATE]. According to the September 2024 CPO, the diagnoses included congestive and diastolic congestive heart failure, acute kidney failure and PTSD.</p> <p>The 7/30/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was dependent on staff assistance with toileting hygiene and showering/bathing self. He required substantial/maximal assistance with lower body dressing, putting on/taking off footwear, sitting to standing, chair/bed to chair transfer, toileting transfer and tub/shower transfer.</p> <p>B. Record review</p> <p>The medications care plan, revised on 8/13/24, documented Resident #4 prescribed mirtazapine (for appetite stimulation) and duloxetine HCl (pain medication). Interventions included administering antidepressant medications as ordered by the physician, monitoring/documenting side effects and effectiveness every shift, educating the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressant drugs being given, monitoring/documenting/reporting as needed adverse reactions to antidepressant therapy and monitoring for changes in behavior/mood/cognition.</p> <p>The depression care plan, revised on 8/13/24, documented Resident #4 had been diagnosed with depression however was not currently on a medication to treat it specifically. Resident #4 was prone to exhibiting the following behaviors that needed to be monitored: depressed mood, isolation, appetite changes and low energy. Interventions included assisting the resident in developing/providing resident with a program of activities that was meaningful and of interest, encouraging and providing opportunities for exercise, encouraging the resident to express his feelings and giving him time to talk, monitoring/documenting/reporting as needed any signs or symptoms of depression, including hopelessness, anxious or health-related complaints and tearfulness.</p> <p>-Review of Resident #4's comprehensive care plan did not reveal a care plan related to his diagnosis of PTSD post-traumatic stress disorder to include person-centered individualized interventions, personalized triggers or personalized signs and symptoms.</p> <p>The 2/8/24 psychosocial evaluation documented Resident #4 was very pleasant. There were no psychosocial signs or symptoms noted at that time.</p> <p>The 8/13/24 social services quarterly assessment documented Resident #4 reported no depression.</p> <p>-The assessment did not indicate the resident had a diagnosis of PTSD.</p> <p>-Review of Resident #4's EMR did not reveal the facility had determined what triggered Resident #3's PTSD.</p> <p>IV. Staff interview</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The social service director (SSD) was interviewed on 9/4/24 at 3:41 p.m. The SSD said the social services department was responsible for completing a depression screening and offering psychiatric services based on a diagnosis of trauma. She said if the resident had PTSD from Vietnam or was having nightmares that she would refer the resident for psychiatric services. She said if a resident was receiving psychiatric services she would make sure the residents' needs were being met. She said social services was responsible for making sure care plans were implemented and updated. She said care plans should be updated as needed and quarterly. She said Resident #3 had a diagnosis of PTSD and anxiety. She said Resident #3 was not prescribed any medications for his PTSD.</p> <p>The SSD said she did not know that Resident #4 had a diagnosis of PTSD. She said she did not know that he did not have a care plan addressing his PTSD. She said social services was responsible for implementing care plans for behaviors.</p> <p>The SSD said she was not a licensed social worker, so she did not feel comfortable doing a trauma assessment for residents. She said there was not another designated staff member to complete trauma assessments. She said she understood that resident's triggers needed to be identified. She said she now knew what areas she needed to work on improving. She said she would work on getting these areas fixed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on record review and interviews, the facility failed to ensure one (#2) of three residents reviewed for psychosocial concerns out of four sample residents received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Provide Resident #2 with psychosocial support who had increasing depression since February 2024; -Update Resident #2's comprehensive care plan to identify the resident's increasing depression and recent wish to die; and, -Develop a comprehensive care plan that depicted Resident #2's accurate antidepressant medication. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Psychosocial Evaluation policy and procedure, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 2:30 p.m. It revealed in pertinent part, The community will evaluate and intervene in residents' psychosocial unmet needs to improve their well-being.</p> <p>A member of the interdisciplinary team (IDT) notices the resident has element(s) of psychosocial unmet needs, such as but not limited to: self-injurious behavior; anger, agitation and/or distress that caused aggression - hitting, shoving, biting, suicide ideation, crying, moaning, screaming, expressions of avoidable pain that is severe, fear or anxiety that may be manifested as panic, immobilization, screaming, trembling, avoidance, resistance to care, sleeplessness, fear of speaking.</p> <p>That IDT member initiates the psychosocial evaluation and notifies the supervisor. Each IDT member completes their section of the evaluation, if appropriate.</p> <p>The social services member completes the evaluation.</p> <p>II. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age 79, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included major depressive disorder and aphasia (language disorder that affects a person's ability to communicate due to damage to the brain's language centers).</p> <p>The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The assessment indicated that the resident felt down, depressed and hopeless nearly every day, felt bad about herself or that she was a failure nearly every day, had trouble concentrating two to six days (several days) during the assessment period with a total PHQ-9 (Patient Health Questionnaire for depression) severity score of seven out of 27, which indicated that the resident had mild depression.</p> <p>B. Resident's representative interview</p> <p>The resident's representative was interviewed on [DATE] at 1:00 p.m. She said Resident #2 had been having a hard time mentally. She said Resident #2 had increasing depression and the facility was not providing psychosocial support. She said social services did not refer Resident #2 to the psychologist until she insisted upon it in [DATE].</p> <p>C. Record review</p> <p>The [DATE] CPOs revealed the following physician orders:</p> <ul style="list-style-type: none"> -Sertraline HCl (Zoloft) (antidepressant medication) oral tablet 100 mg (milligram), give one tablet by mouth one time per day for depression, ordered on [DATE]; -Monitor for depressed mood, crying or tearful, self-isolation, appetite changes, and/or feeling bad about herself. If the behavior occurs. Document in the behavior progress notes description of the behavior, non-pharmacological interventions, and resident response. Every shift for behavioral monitoring. Monitoring interventions that can be used are: re-positioning, offer a snack/drink, redirect to an activity, offer independent activity supplies, offer to call a loved one, assist outside, sit with resident as needed, active listening and validation, ordered on [DATE]; and, -MediTelecare to evaluate and treat for psychiatric and psychological help, ordered on [DATE]. <p>The antidepressant medication care plan, initiated on [DATE] and revised on [DATE], documented that the resident used the anti-depressant medication of Lexapro.</p> <p>-The care plan was inaccurate as the resident was not currently prescribed Lexapro, but instead Zoloft, which was originally prescribed on [DATE].</p> <p>The [DATE] PHQ-9 documented Resident #2 felt tired or had little energy two to six days per week. The resident scored a two out of 27, which indicated no to minimal depression.</p> <p>The [DATE] nursing progress note documented Resident #2 said she stayed in bed all day. I just did not feel like getting up. My appetite is off, I am not hungry and nothing tastes right.</p> <p>The [DATE] physician progress note documented Resident #2 was very tearful and stated she would like to die, but does not have a plan. The physician recommended to refer the resident to psychology services and increase the Zoloft.</p> <p>-However, the resident was not referred to psychological services until [DATE], at the insistence of the resident's responsible party.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	
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)		
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The [DATE] PHQ-9 documented by social services, indicated Resident #2 had little interest or pleasure in doing things, felt tired or had little energy and felt bad about herself or has let her family down with a score of three out of 27, which was a one point increase from February 2024 and indicated minimal depression.</p> <p>-Social services documented that the resident had a recent evaluation confirming the resident had dementia and had been taking the diagnosis hard and caused tearfulness or isolation, however record review did not reveal additional psychosocial support was provided to the resident by social services, including a psychological evaluation referral that was not completed until [DATE].</p> <p>The [DATE] nursing progress note documented the resident was informing her family and staff that she is ready to die. I have lived a good life and it is time for me to go. The nurse documented that she sat with the resident and said Resident #2 would be missed if she died tonight and informed the resident staff would check on her through the night.</p> <p>-The resident was placed on monitoring for three days, however a review of the resident's electronic medical record (EMR) did not reveal documentation that social services had met with the resident and provided additional psychosocial support.</p> <p>The [DATE] physician progress note documented that Resident #2's anxiety and depression was severe. The resident was very tearful and perseverated on death and not wishing to be alive any longer. Resident #2 said she felt she was a burden to her family.</p> <p>The [DATE] PHQ-9 documented Resident #2 felt down, depressed or hopeless almost every day, felt bad about herself or that she was a failure or have let her family down every day and had trouble concentrating two to six days of the assessment period with a score of seven out of 27.</p> <p>-Resident #2 had a four point increase on the [DATE] PHQ-9 assessment since [DATE].</p> <p>-A review of the resident's EMR did not reveal documentation that the resident had been provided psychosocial supportive services by the social services department, other than a referral to psychology services on [DATE], which was prompted by the resident's family member, not the facility staff (see resident representative interview).</p> <p>The mood care plan, initiated on [DATE] and revised on [DATE], documented Resident #2 had a diagnosis of depression. It indicated to monitor for the following: depressed mood, crying or tearful, self-isolation, appetite changes, and/or feeling bad about herself.</p> <p>The interventions, which had not been revised since [DATE], documented arranging for a psych consult, following up as indicated encouraging the resident to express her feelings and give her time to talk, providing adequate rest periods, encouraging and reminding the resident to rest throughout the day, providing re-positioning, offering a snack/drink, redirecting the resident to an activity, offering independent activity supplies, offering to call a loved one, assist outside sit with resident as needed, providing active listening and validation and monitoring/documenting/reporting any signs and symptoms of depression.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Sunny Vista Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2445 E Cache LA Poudre St Colorado Springs, CO 80909	

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)
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The care plan did not address Resident #2's PHQ-9 score increased since February 2024 from two (no or minimal depression) to seven (mild depression) on [DATE]. It did not address the resident's recent statement of being ready to die and referral to psychiatric services, nor any identified behaviors of depression or triggers for depression.</p> <p>III. Staff interviews</p> <p>The social services director (SSD) and the director of nursing (DON) were interviewed together on [DATE] at 3:40 p.m. The SSD said PHQ-9's were completed for every resident every quarter, annually and as needed by the social services department. She said the PHQ-9 score determined if a resident was offered psychological services.</p> <p>The SSD said upon completion of the PHQ-9, the social worker reviewed the potential need for psychological services and ensured the referral was provided. She said social services was responsible for developing the mood and behavior care plan.</p> <p>The SSD said the care plan should be reviewed and updated every quarter, annually and as needed with signs and symptoms of depression. She said any changes in a resident's mood or behavior should be updated on the care plan.</p> <p>The SSD said Resident #2 was admitted to the facility for rehabilitation, however ended up staying under long-term care. She said the resident had difficulty adjusting at first, but made a male friend who she spent a lot of time with.</p> <p>The SSD said Resident #2 had noted depression and had recently been referred to a counselor and psychiatrist.</p> <p>The SSD said she was not aware Resident #2's PHQ-9 had been increasing which indicated the resident had worsening depression. She confirmed the care plan had not been updated with Resident #2's worsening depression or recent statement of wanting to die.</p> <p>The SSD confirmed the facility did not have any documentation indicating the resident had received additional psychosocial support through her worsening depression, other than a referral to psychological services.</p> <p>The SSD confirmed the care plan documented in the resident's medical record documented that the resident was taking the antidepressant Lexapro. The SSD said Resident #2 was no longer prescribed Lexapro, but was instead prescribed Zoloft.</p>