STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065307	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

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 - 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** 32259 Based on interviews and record review, the facility failed to take steps to protect one (#10) of six residents reviewed for abuse out of 24 sample residents. Resident #10, who had a diagnosis of anxiety disorder and was always incontinent of urine and occasionally incontinent of bowel, was dependent on staff assistance for all activities of daily living (ADL), including toileting hygiene, showering, upper and lower body dressing, personal hygiene and transfers. She required maximal assistance from staff to propel her wheelchair. She was able to use her call light to call staff when she needed assistance. On 5/3/24, certified nurse aide (CNA) #2 provided a shower to Resident #10. After the resident's shower, CNA #2 placed Resident #10 in her wheelchair near the bathroom in her room. CNA #2 left Resident #10's room, without making the resident's bed and without telling the resident she would be back or why she was leaving the room and closed the door of the room. Resident #10 was unable to maneuver her wheelchair independently in order to reach her call light, which was left approximately eight feet away from her, to call for assistance. Resident #10 began to feel afraid and began yelling out for help because she could not reach her call light. After 20 minutes, the resident's family member arrived for a visit. The family member heard Resident #10 yelling from the hallway, opened Resident #10's door, found the resident crying and upset and went to find a staff member (CNA #1) who could provide assistance to the resident. Additionally, on several occasions between 3/1/24 and 5/5/24, Resident #10's call light was on for 15 minutes or more before staff provided assistance to the resident. Due to the facility's failure, Resident #10 was afraid when she was left unattended and without access to the call light for 20 minutes. She felt abandoned, like she did not matter and that staff would forget her. Findings include: I. Facility policy and procedures (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Resident Abuse Prevention policy and procedure, dated August 2017, was provided by the executive director (ED) on 5/10/24 at 5:25 p.m. The policy documented each resident had the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and physical or chemical restraints. Neglect was defined as a failure to provide agreed upon care or services to a resident, failure to make a reasonable effort to assess what care was necessary for the well-being of the resident, or failure to provide a safe and sanitary environment. The Resident Call System policy and procedure, dated August 2017, was provided by the ED on 5/10/24 at 5:25 p.m. The policy documented each resident was provided with a means to call staff directly for assistance, and calls for assistance were answered as soon as possible, but no later than five minutes. Urgent requests for assistance were addressed immediately. II. Resident #10 A. Resident status Resident #10, age 86, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included rheumatoid arthritis, anxiety disorder, Parkinsonism (term for a group of brain conditions that cause movement symptoms, such as slow movements, stiffness, walking and balance problems and tremors) and weakness. The 3/6/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on staff for toileting hygiene, showering, upper and lower body dressing, personal hygiene and transfers. She had no hallucinations, delusions or refusals of care. She was always incontinent of urine and occasionally incontinent of bowel. She required substantial/maximal assistance with the use of her wheelchair. B. Resident interview and observations Resident #10 was interviewed on 5/7/24 at 11:08 a.m. Resident #10 said there were times when she had to wait for 30 minutes or more for assistance from staff when she needed help. She said there was an incident the previous Friday (5/3/24) when she was left in her wheelchair in her room by a staff member who had just helped her bathe but did not finish and she did not have access to her call light. Resident #10 said CNA #2 placed her wheelchair near the bathroom, which was approximately eight feet away from where her call light was. She said CNA #2 left the room, closed the door without telling her she would be back or why she needed to leave and left the resident alone for 20 minutes without ensuring the call light was within reach. Resident #10 said she began to feel afraid and started yelling out for help to get her back into bed. She said her bed did not have any linens on it and had not been made. She said she felt abandoned and as if she did not matter. Resident #10 began to cry during the interview and said she had so many fears about that, and did not like the door to her room closed because she felt like the staff was going to forget her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #10 said after approximately 20 minutes, her family member arrived for a visit, heard her yelling out for help from the hallway and opened the door and found her crying and upset. She said her family member told her she would make her bed and went to find a staff member (CNA #1) who could provide them with linens and assistance. Resident #10 was interviewed again on 5/10/24 at 10:23 a.m. Resident #10 said if staff took too long to answer her call light, she was incontinent of urine which made her bottom sore. She said she wore an incontinence brief and needed to be changed routinely, which was usually why she pushed the call light for help. Resident #10 became tearful and said sometimes it took half an hour to answer her call light, which was too long, and she said it made her feel like she didn't matter and she didn't count. C. Record review The care plan, initiated 6/5/23 and revised 5/10/24, identified Resident #10 had limitations in her ability to perform activities of daily living. Interventions included she required extensive assistance of two staff with bed mobility, position changes, dressing, personal hygiene and bathing. The resident experienced incontinence and required extensive assistance of two staff with toileting and was encouraged to use a call bell to call for assistance. The Past Calls log for Resident #10's use of the call light was reviewed from 3/1/24 through 5/5/24 and revealed the following response times: -The call light elapsed response time was greater than 15 minutes 54 times. -Of those 54 occasions, the response time was greater than 20 minutes 16 times. -Further, on 4/13/24, there was a response time of 30 minutes and on 4/30/24, there was a response time of 56 minutes. III. Incident of neglect of Resident #10 by CNA #2 The investigation was reviewed for the incident that occurred on 5/3/24 when Resident #10 was left without access to her call light. In summary, CNA #2 left the resident's room when they returned from the bathing room to obtain sheets to make the bed. CNA #2 went to the laundry room to wait for the dryer to finish drying the linens and when she returned to the resident's room, the bed had already been made. CNA #2 left the room to request staff assistance to place the resident back in bed. CNA #2 was unfamiliar with Resident #10 and did not know her routine. The Investigatory Interview Form for the incident on 5/3/24, completed by the social services director (SSD), was reviewed and documented Resident #10 said she was left in her room without her sheets being changed, assisted back to bed and no call light was provided. The documentation revealed CNA #2 apologized to the resident when she returned to the room, and Resident #10 said she did not like that she was left. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The incident was reported and submitted to the State agency. IV. Staff interviews The SSD was interviewed on 5/10/24 at 12:27 p.m. The SSD said she was asked to follow up with Resident #10 about the incident that occurred on 5/3/24. The SSD said Resident #10 told her she could not reach her call light for 20 minutes after her shower and said, It is not fair because I could not do anything when she was unable to get help. The SSD said it was important for residents to have access to their call lights because it was the only way they could get their needs met, especially if they were not mobile. She said having the call light within reach could prevent possible falls, in case of emergencies, if they needed medicines or had pain or if someone was in their room who should not be. CNA #1 was interviewed on 5/10/24 at 2:47 p.m. CNA #1 said she routinely worked with Resident #10. She said the resident required assistance with dressing, personal hygiene, transfers and toileting and the amount of care she could provide for herself changed over time. She said she thought the resident might be getting weaker. CNA #1 said the resident was incontinent of urine most of the time and was usually wet when she would use her call light to request personal hygiene assistance. CNA #1 said the resident used her call light purposefully and there had always been a reason she needed help when she pushed it. CNA #1 said, on 5/3/24, she was working on a different hall than Resident #10 was on. She said the resident's family member came and got her to request assistance for Resident #10. She said when she entered the resident's room, the resident was crying, frustrated and really upset. She said the call light was not on and was across the room and not within the resident's reach. CNA #1 said CNA #2 was new to the facility and not very familiar with the resident. She said CNA #2 had left Resident #10 in her wheelchair after her shower which the staff usually did not do. CNA #1 assisted the resident to finish putting lotion on her face, changed the bed linens and got her back into bed. CNA #1 said the resident was very particular, and the staff did get busy at times, but she said if it had been her in that position, she probably would have felt abandoned, been crying and upset as Resident #10 had been. CNA #1 said she dropped everything she was doing to take care of the resident as if it had been her in that position. CNA #1 said residents' call lights should be left right next to them, within reach, even for the independent residents, in case they needed assistance. The ED was interviewed on 5/10/24 at 6:22 p.m. The ED said residents should have their call lights within reach at all times. She said, in the past, if she had identified a resident who did not have their call light within reach, she would give it to them, then go to the nurses' station and tell the staff to go make a sweep of all of the residents on the floor to make sure everyone had their call light within reach. She said Star rounds were rounds conducted three times each week by a dedicated management staff and that was one of the things they checked on for each resident during those rounds. -During the survey, CNA #2 had been suspended pending the abuse investigation and was unavailable for an interview. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V. Facility follow-up The facility provided additional documentation on 5/13/24, after the survey exit. The documentation included an investigation that was conducted into the call light wait time of 56 minutes on 4/30/24 at 8:39 p.m. The investigation documented Resident #10 became upset when an agency CNA entered her room to provide hour of sleep care and she preferred to not have someone new providing her care. She became visibly agitated and asked the agency CNA to leave the room. The registered nurse (RN) caring for Resident #10 that evening was then approached by another CNA with an urgent concern from another resident that needed to be addressed. The facility alleged that the call light in Resident #10's room was not turned off after care was provided to her by the RN and a different CNA because they forgot to turn it off. -However, there was no additional documentation provided to explain the 4/13/24 call light response time of 30 minutes or the other extended response times of greater than 15 or 20 minutes for Resident #10.