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	04/02/2025

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 - 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** 40467 Based on record review and interviews, the facility failed to ensure one (#7) of five residents reviewed were free from abuse out of 13 sample residents. Specifically, the facility failed to ensure Resident #7 was free from physical abuse by Resident #3. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation-Investigating and Reporting policy, revised September 2022, was provided by the director of nursing (DON) on 4/2/25 at 3:34 p.m. The policy read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by the facility management. Findings of all investigations are documented and reported. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of Resident property or injury of unknown source, the administrator is responsible for determining what actions are needed (if any) for the protection of residents. II. Incident of physical abuse of Resident #7 by Resident #3 A. Incident of physical abuse on 3/10/25 The 3/10/25 incident report was provided by the DON on 4/2/25 at 5:05 p.m. The incident report revealed Resident #7 reported to a nurse and a certified nurse aide (CNA) that Resident #3 pinched his leg on 3/10/25 at 8:30 p.m. According to the report, another CNA witnessed the altercation. The incident report identified the CNA was pushing Resident #3 (in her wheelchair) to her room when Resident #3 leaned out from the wheelchair and pinched Resident #7. Resident #7 said ouch in response to the pinching. The incident report documented there were no injuries at the time of the incident or post incident. The nurse manager contacted the nurse practitioner, the on call nurse manager and the residents' representatives. B. Resident #7 (victim) (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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(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	1. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included unspecified disorder of psychological development, lack of coordination, difficulty in walking, unqualified vision loss in the left eye, cerebral palsy, cerebellar ataxia (movement disorder, reduced mobility, dependence on a wheelchair, weakness and contracture of the right and left lower leg muscles. The 2/4/25 minimum data set (MDS) assessment documented Resident #7 had severe cognitive impairments with a brief interview of mental status (BIMS) score of seven out 15. The resident presented with inattention and disorganized thinking. The MDS assessment indicated Resident #7 did not exhibit verbal, physical or other behavioral symptoms directed towards others. He had upper extremity impairment to one side and lower extremity impairment to both sides. He used a manual wheelchair for mobility. 2. Record review The at-risk care plan, revised 4/12/22, identified Resident #7 was an at-risk adult due to a developmental delay. The care plan goal was to keep Resident #7 free from abuse. The interventions, revised 7/12/24, directed staff to observe Resident #7's interactions with others closely for safety, to provide emotional support and the opportunity for him to express himself and to thoroughly investigate allegations of abuse per policy and regulation. The 1/31/25 physical aggression care plan identified Resident #7 was a prior victim of physical aggression from another resident. According to the care plan, Resident #7 would remain safe and free from physical aggression from others. The 1/31/25 intervention directed staff to immediately separate Resident #7 and the other resident during incidents of physical aggression. The 3/17/25 intervention directed staff to monitor Resident #7's psychosocial well-being related to the physical aggression he received. The 3/10/25 alert note documented Resident #7 reported that another resident pinched his leg. The note indicated the resident's left thigh was assessed and there was no redness, bruising or open areas identified. According to the note, Resident #7 said his leg no longer hurt but it did at the time of the incident. The 3/17/25 IDT (interdisciplinary team) note documented the IDT met and reviewed the physical aggression received by Resident #7. The note identified Resident #7 often sat in his wheelchair in his room doorway or in the hall near his room. He has some difficulty communicating with other residents which may have led to intermittent tension. Resident #7 was reminded to ask staff for help when needed and to keep the halls clear when possible. The note read the resident often blocked the hallway with his chair while visiting with others. The IDT indicated his care plan was updated. C. Resident #3 (assailant) 1. Resident status (continued on next page)

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(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	Resident #3, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included unspecified dementia, and unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The 2/27/25 minimum data set (MDS) assessment documented Resident #3 had severe cognitive impairments with a BIMS score of two out 15. The resident presented with inattention and disorganized thinking. According to the MDS assessment, she did not have an upper extremity impairment and was able to propel her manual wheelchair for short and long distances. The MDS assessment indicated Resident #3 had physical and verbal behavioral symptoms directed at others. The MDS assessment identified her behaviors impacted others and put them at risk for physical injury. 2. Observations On 4/2/25 at 3:42 p.m. Resident #3 pounded on the side of the housekeeper's cart. A CNA asked her what she needed and moved her away from the cart. At 4:21 p.m. Resident #3 was sitting at the nurse's station when a male resident walked up to the nurse's station. Resident #3 proceeded to loudly yell at the male resident to shut his mouth and started to hit the wall in front of the nurse's station until the male resident walked away. An unidentified staff member at the nurse's station and licensed practical nurse (LPN) #2, who was in the hallway, observed the interaction but did not intervene. 3. Record review The adjustment care plan, initiated 2/4/25, indicated Resident #3 had difficulty transitioning to the facility. The interventions were to contact her family when she became upset or exhibited verbal/physical aggression and speak to her in a calm tone. The anti-psychotic medication care plan, initiated 2/21/25, identified Resident #3 was administered Seroquel (antipsychotic) for her dementia related to agitation and aggression. The care plan interventions directed staff to complete behavior tracking for the resident's increased aggression and elopement tendencies. The behavior care plan, initiated 3/17/25, revealed Resident #3 may become physically and/or verbally aggressive towards staff and others due to poor impulse control, dementia and history of harm to others. The behavioral care plan interventions directed staff to provide Resident #3 with physical and verbal cues to alleviate anxiety, give her positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage her to seek out a staff member when agitated and, give the resident as many choices as possible about care and activities. The care plan identified Resident #3 could be physically aggressive towards others, usually due to sundowning (increased confusion later in day and or evening). According to the care plan, staff should attempt to redirect the behavior. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2025 CPO revealed a physician's order that directed staff to monitor Resident #3's behavior every shift for behaviors of hitting herself or increased agitation, ordered 1/29/25. Review of the January 2025 (1/1/25 to 1/31/25), the February 2025 (2/1/25 to 2/28/25) and the March 2025 (3/1/25 to 3/31/25) treatment administration records (TAR) for Resident #3 documented she hit herself and/or had agitation, on at least one shift, 22 times between 1/29/25 and 3/9/25. Review of progress notes between January 2025 and March 2025 identified Resident #3 exhibited multiple incidents of verbal and physical aggression towards staff, including hitting a staff member with her shoe and slapping a staff member. The 2/20/25 IDT note documented Resident #3 had frequent verbal and physical behaviors that were increasingly aggressive in the afternoon. According to the note, the intervention was to add a new medication to increase the resident's comfort. The 3/10/25 alert note for Resident #3 identified the 3/10/25 witnessed physical altercation between Resident #3 and Resident #7. According to the note, the CNA asked the resident to apologize after Resident #3 pinched Resident #7 on the leg. Resident #3 apologized and then Resident #3 was assisted to her room. The March 2025 TAR did not identify Resident #3 exhibited behaviors on 3/10/25, the day she pinched Resident #7. The 30-day response history for behavioral symptoms for Resident #3 did not identify Resident #3 had physical aggression directed to others on 3/10/25. According to the response history, the resident did not have any behaviors on 3/10/25. The 3/10/25 eInteract situation, background, assessment, response (SBAR) summary for providers note documented Resident #3 had physical aggression. According to the note, the recommendation in response to the behavior was redirection and monitoring and reporting worsening behaviors. The 3/20/25 interdisciplinary note (IDT) note documented Resident #3 lacked impulse control, experienced cognitive decline related to disease process and required frequent redirection during episodes of verbal and physical aggression. The note identified the physician was notified and ongoing monitoring and behavior tracking continued. III. Resident interviews Resident #11 was interviewed on 4/1/25 at 11:12 a.m. Resident #11 said there was a resident who yelled all the time in the dining room. She said recently, the resident entered her room and started yelling at her. Resident #11 identified the resident as Resident #3. Resident #11 said staff were aware Resident #3 was yelling at her in her room. Resident #12 and Resident #13 were interviewed together on 4/1/25 at 11:25 a.m. Resident #12 said there was a resident that was always yelling and touching other residents. Resident #12 said she would pinch other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 identified the resident as Resident #3. Resident #13 said Resident #3 would poke and hit staff. Both Resident #12 and Resident #13 denied being touched by Resident #3, but said they had seen it happen to other people. IV. Staff interviews CNA #3 was interviewed on 4/2/25 at 9:30 a.m. CNA #3 said Resident #3 was usually calm, easy to redirect and more cognizant in the morning. She said her behaviors usually increased after 2:00 p.m. and she was harder to redirect. The nursing home administrator (NHA) was interviewed on 4/2/25 at 10:25 a.m. The NHA said abuse prevention started with making sure the staff were appropriately trained to help prevent abuse occurrences. CNA #4 was interviewed on 4/2/25 at 10:42 a.m. CNA #4 said Resident #3 had good behaviors in the mornings but in the afternoons and evenings, she sundowned (increased confusion and agitation in the afternoon) and could be mean and aggressive. The DON was interviewed on 4/2/25 at 12:51 p.m. The DON said allegations of abuse should be reported to the nurse, the nurse leadership, including the DON, and the NHA should be alerted. She said the facility would then talk with staff and find out what happened. The NHA was interviewed again on 4/2/25 at 4:25 p.m. The NHA said after Resident #3 pinched Resident #7, the facility did a risk management review and felt the incident did not rise to the level of abuse. He said the pinching did occur but there was no potential for harm. The NHA said Resident #7 said ouch when he was pinched. He said Resident #7 may have said ouch out of a response to the pinching, but it might not have indicated he was in pain. The DON was interviewed again on 4/2/25 at 5:08 p.m. The DON said Resident #3 pinched Resident #7 on the leg and he said ouch. She said the incident was a resident-to-resident altercation. She said the IDT reviewed the incident and determined the pinching was intentional. She said the intervention after the incident was communicating with hospice and the resident's family. She said the family decided they wanted to move Resident #3 closer to other family members who could be more involved. The DON said the facility was currently in the process of seeking appropriate placement closer to the family. The DON said after the 3/10/25 incident, the facility implemented increased rounding and safety checks on Resident #3. She said the checks were not formal or documented. She said prior to the 3/10/25 resident-to-resident altercation, staff were not concerned about Resident #3's behaviors as a safety risk to other residents. The DON said since 3/10/25, Resident #3's behaviors had continued to progress. She said staff were now more aware and observant. The DON said resident-to-resident incidents were updated in the care plan as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property for three (#7, #8 and #3) of seven residents out of 13 sample residents. Specifically, the facility failed to: -Report an allegation of physical abuse towards Resident #7 by Resident #3 to the State Agency; -Report an allegation of sexual abuse towards Resident #8 by Resident #3 to the State Agency; and, -Report an allegation of sexual abuse towards Resident #3 by Resident #9 to the State Agency. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation-Investigating and Reporting policy, revised September 2022, was provided by the director of nursing (DON) on 4/2/25 at 3:34 p.m. The policy read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by the facility management. Findings of all investigations are documented and reported. II. Incident of physical abuse of Resident #7 by Resident #3 A. Facility investigation The 3/10/25 incident report was provided by the DON on 4/2/25 at 5:05 p.m. The incident report revealed Resident #7 reported to a nurse and a certified nurse aide (CNA) that Resident #3 pinched his leg on 3/10/25 at 8:30 p.m. According to the report, another CNA witnessed the altercation. The incident report identified the CNA was pushing Resident #3 (in her wheelchair) to her room when Resident #3 leaned out from the wheelchair and pinched Resident #7. Resident #7 said ouch in response to the pinching. The incident report documented there were no injuries at the time of the incident or post-incident. The nurse manager contacted the nurse practitioner, the on call nurse manager and the residents' representatives. -The facility did not report the incident of physical abuse to the State Agency until 4/2/25 (during the survey), 22 days after the incident occurred. C. Resident #7 (victim) 1. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included unspecified disorder of psychological development, lack of coordination, difficulty in walking, unqualified vision loss in the left eye, cerebral palsy, cerebellar ataxia (movement disorder, reduced mobility, dependence on a wheelchair, weakness and contracture of the right and left lower leg muscles. The 2/4/25 minimum data set (MDS) assessment documented Resident #7 had severe cognitive impairments with a brief interview of mental status (BIMS) score of seven out 15. The resident presented with inattention and disorganized thinking. The MDS assessment indicated Resident #7 did not exhibit verbal, physical or other behavioral symptoms directed towards others. He had upper extremity impairment to one side and lower extremity impairment to both sides. He used a manual wheelchair for mobility. 2. Record review The 3/10/25 alert note documented Resident #7 reported that another resident (Resident #3) pinched his leg. The note indicated the resident's left thigh was assessed and there was no redness, bruising or open areas identified. According to the note, Resident #7 said his leg no longer hurt but it did at the time of the incident. The 3/17/25 IDT (interdisciplinary team) note documented the IDT met and reviewed the physical aggression received by Resident #7. D. Resident #3 (assailant) 1. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included unspecified dementia, and specified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The 2/27/25 MDS assessment documented Resident #3 had severe cognitive impairments with a BIMS score of two out 15. According to the MDS assessment, she did not have an upper extremity impairment and was able to propel her manual wheelchair for short and long distances. The MDS assessment indicated Resident #3 had physical and verbal behavioral symptoms directed at others. The MDS assessment identified her behaviors impacted others and them at risk for physical injury. 3. Record review The 3/10/25 alert note documented a witnessed physical altercation occurred between Resident #3 and Resident #7. According to the note, the CNA asked the resident to apologize after Resident #3 pinched Resident #7 on the leg. Resident #3 apologized and then Resident #3 was assisted to her room. The 3/20/25 interdisciplinary note (IDT) note documented Resident #3 lacked impulse control, experienced cognitive decline related to disease process and required frequent redirection during episodes of verbal and physical aggression. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Allegation of sexual abuse by Resident #3 towards Resident #8 on 3/16/25 -The facility did not report the allegation of sexual abuse by Resident #3 towards Resident #8 to the State Agency until 4/2/25 (during the survey), which was 16 days after the incident occurred. A. Resident #8 (victim) 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, anxiety disorder, major depressive disorder, recurrent, mild, abnormalities of the gate and mobility, weakness, and unsteadiness on his feet. The 2/12/25 MDS assessment documented Resident #8 was cognitively intact with a BIMS score of 13 out 15. The resident did not exhibit inattention and disorganized thinking. He required partial to moderate staff assistance with transfers from surface to surface and bed mobility. He used a manual wheelchair for mobility, According to the MDS assessment, he did not have an upper extremity impairment and was able to propel her manual wheelchair for short and long distances. Resident #8 did not exhibit behaviors directed at others. 2. Resident #8 interview Resident #8 was interviewed on 4/2/25 at 1:58 p.m. Resident #8 said Resident #3 was sitting next to him in an activity on 3/16/25 when she put her hand under his shirt. Resident #8 said Resident #3 put her hand in the sleeve of his t-shirt and proceeded to move her hand down his shirt and up against his side by his ribs. Resident #8 said Resident #3 started to move her fingers in a tapping fashion. He said he told her to stop but she continued, even after he told her to stop. He said Resident #3 continued to touch him in this manner for a couple minutes until the staff came over and stopped it. Resident #8 said the incident made him very uncomfortable. He said he felt Resident #3 was inappropriate towards him. He said he did not want to be around her and it would be uncomfortable if he was near her again. Resident #8 said Resident #3 came into his room last night (4/1/25) and was sitting by his bathroom while he was in bed until staff removed her. He said he was very wary of doing anything because she had touched him before. He said he had also seen that she had very aggressive behaviors and hit and pounded on things with her fists. 3. Record review The review of Resident #8's progress notes did not identify the 3/16/25 allegation of sexual abuse or facility follow-up with Resident #8 after the incident. B. Resident #3 (assailant) 1. Record review (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/16/25 behavior note documented Resident #3 was observed touching another resident (Resident #8) inappropriately. According to the note, the other resident (Resident #8) reported that Resident #3 stroked his arm and side. When Resident #8 asked her to stop, she responded with you know you like it. The note indicated Resident #3 was then redirected with an activity. IV. Allegation of sexual abuse by Resident #9 towards Resident #3 on 3/31/25 A. Facility investigation The 3/31/25 incident report was provided by the DON on 4/2/25 at 5:08 p.m. The incident report identified Resident #9 was sexually inappropriate with another resident (Resident #3). Resident #9 hit the registered nurse (RN) in the face and cursed at her when she attempted to separate both residents. According to the incident report, Resident #9 was taken to his room and told his behaviors were highly inappropriate. The incident report documented the residents were not injured. The report identified the physician was notified on 3/31/25. -The facility did not report the alleged sexual abuse to the State Agency until 4/2/25 (during the survey, which was over 24 hours after Resident #9 was sexually inappropriate towards Resident #3. C. Resident #3 1. Record review The 3/31/25 note documented RN #2 responded to a reported event. The note documented another resident (Resident #9) exposed his genitals to Resident #3. The note indicated the RN immediately removed the other resident (Resident #9) from the situation. According to the note, neither resident could say exactly what had happened and Resident #3 could not identify who she was speaking with at the time of the incident. The note identified Resident #3's representative and the hospice staff were alerted to the situation. D. Resident #9 (assailant) 1. Resident status Resident #9, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 CPO, diagnoses included personal history of traumatic brain injury (TBI), bipolar disorder, lack of coordination and the dependence on a wheelchair. The 2/28/25 MDS assessment documented Resident #9 was cognitively intact with a BIMS score of 13 out 15. The MDS assessment indicated Resident #9 had fluctuating difficulty focusing his attention. He had lower extremity impairment to both sides. The resident did not have upper extremity impairment. He used a manual wheelchair and required substantial to maximum staff assistance for mobility. According the MDS assessment Resident #9 did not exhibit behaviors directed at others or rejections of care. 2. Record review (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/31/25 eInteract situation, background, assessment, response (SBAR) summary for providers note documented Resident #9 had a change of condition related to physical aggression/verbal aggression. -The note did not identify Resident #9's sexually inappropriate behavior of exposing himself to Resident #3. The 4/1/25 IDT note identified the IDT met to review Resident #9's physical aggression According to the note, Resident #9 had a history of sexually inappropriate behaviors and verbal and physical aggression. The intervention was for the nursing home administrator (NHA) to speak with Resident #9 and his representative related to his behaviors and update the resident's plan of care to ensure safety of staff and residents. V. Staff interviews RN #2 was interviewed on 4/1/25 at 4:40 p.m. RN #2 said on 3/31/25 Resident #9 exposed his genitals to Resident #3. She said a dietary aide reported the incident to her and several other staff members also saw it happen. RN #2 said when she separated the two residents, Resident #9 attempted to hit her. She said she was not aware of other incidents of sexual behavior involving Resident #9. RN #2 said she reported the incident to the nurse supervisor and to the DON. The NHA was interviewed on 4/2/25 at 10:25 a.m. The NHA said abuse prevention started with making sure staff was appropriately trained to help prevent abuse occurrences. He said all potential abuse allegations should be investigated and reported to the State Agency. He said if there was injury involved in the allegation, the facility should report the allegation/incident within two hours of the occurrence. The NHA was interviewed again on 4/2/25 at 12:02 p.m. The NHA said the 3/16/25 incident between Resident #3 and Resident #8 was investigated by the nurse manager (NM). The NHA said the incident did not rise to the level of abuse because Resident #8 said Resident #3 just touched his arm. The NM was interviewed on 4/2/25 at 12:20 p.m. The NM said she was the nurse manager a few days a week. She said if an incident occurred on the weekend of her shift, the floor nurse would write up the incident in a progress note. The NM said she would make sure the incident was documented in a note and would look at the risk management process. The NM said on 3/16/25 the floor nurse, licensed practical nurse (LPN) #3, reported to her that another staff member told LPN #3 that they either witnessed or heard that Resident #3 touched Resident #8 and Resident #3 was told to stop. The NM said LPN #3 spoke to Resident #8 after the incident. She said LPN #3 told her Resident #8 said Resident #3 was touching his arm, he told her to stop and Resident #3 asked him if he liked it. CNA #4 was interviewed on 4/2/25 at 10:42 a.m. CNA #4 said Resident #9 recently was showing his genitals out in the open to Resident #3. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 4/2/25 at 12:51 p.m. The DON said allegations of abuse should be reported to the nurse, nurse leadership, including the DON, and the NHA should be alerted. She said the facility would talk with staff and find out what happened. The DON said if the incident was an abuse allegation, it should be reported to the State Agency within 24 hours. She said a reportable sexual abuse allegation would be reported if it was determined that there was inappropriate touching to a resident and if the resident who was touched did not consent. The DON said non-consentual touch could be considered sexual abuse. She said if a resident touched another resident and indicated it was not welcomed by words, such as no or don' t touch me, it could be considered sexual abuse. The DON said Resident #9 was exposing himself to Resident #3 on 3/31/25. She said the nurse assisted him to his room. She said Resident #9 had a history of sexual behaviors. She said she did not know if an investigation was started. She said she did not know if the incident was reported. The NHA was interviewed a third time on 4/2/25 at 1:25 p.m. The NHA said Resident #9 exposed himself on 3/31/25. He said Resident #9 did not expose himself to other residents. He said it was reported to him that Resident #9 exposed himself to RN #2. He said if the incident involved another resident, it needed to be reported to the State Agency. The NHA reviewed the 3/31/25 progress note identifying Resident #9 exposed himself to Resident #3 (see record review above). The NHA said he would see if an investigation was started. The NHA was interviewed a fourth time on 4/2/25 at 4:25 p.m. The NHA said after Resident #3 pinched Resident #7, the facility did a risk management review and felt the incident did not rise to the level of abuse. He said the pinching did occur but there was no potential for harm. The NHA said Resident #7 said ouch when he was pinched. He said the resident may have said ouch out of a response to the pinching but it might not have indicated he was in pain. He said the incident was not reported but he would report it today (4/2/25). The NHA said the facility needed to continue to train the staff on abuse. The NHA said the facility needed to do a better job with investigating alleged abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for two (#7 and #8) of seven residents out of 13 sample residents. Specifically, the facility failed to complete a thorough investigation after: -An allegation of physical abuse towards Resident #7 by Resident #3; and, -An allegation of sexual abuse towards Resident #8 by Resident #3. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation-Investigating and Reporting policy, revised September 2022, was provided by the director of nursing (DON) on 4/2/25 at 3:34 p.m. The policy read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by the facility management. Findings of all investigations are documented and reported. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed (if any) for the protection of residents. Allegations are thoroughly investigated. The administrator initiates investigations. The individual conducting the investigation at minimum: reviews the documentation and evidence; reviews the resident's medical record determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; interviews the person reporting the incident; interviews any witnesses to the incident; interviews the resident (as medically appropriate) or the resident's representative; interviews the resident's attending physician as needed to determine the resident's conditions; interviews staff members (on all shifts) who have contact with the resident during the period of the alleged incident; interviews the resident's roommate, family members, and visitors. According to the policy, the individual conducting the investigation should review all events leading up to the alleged incident and document the investigation completely and thoroughly. The policy documented witness statements should be obtained in writing, signed and dated and a follow-up investigation should occur within five business days of the incident. The follow-up investigation report should include as much information as possible at the time of the submission of the report. The report should have sufficient information to describe the results of the investigation; what corrective actions were taken if the allegation was verified; and, the notification of the outcome of the investigation to the resident/representative. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Incident of physical abuse of Resident #7 by Resident #3 A. Facility investigation The 3/10/25 incident report was provided by the DON on 4/2/25 at 5:05 p.m. The incident report revealed Resident #7 reported to a nurse and a certified nurse aide (CNA) that Resident #3 pinched his leg on 3/10/25 at 8:30 p.m. According to the report, another CNA witnessed the altercation. The incident report identified the CNA was pushing Resident #3 (in her wheelchair) to her room when Resident #3 leaned out from the wheelchair and pinched Resident #7. Resident #7 said ouch in response to the pinching. The incident report documented there were no injuries at the time of the incident or post incident. The nurse manager contacted the nurse practitioner, the on call nurse manager and the residents' representatives. -Review of the provided facility investigation did not include other staff or other residents' interviews after the 3/10/25 incident. -Additionally, the facility failed to investigate if other residents had been involved in altercations with Resident #3 and/or if they felt safe in the facility and free from abuse. Cross reference: F600 failure to protect Resident #7 from physical abuse. B. Resident #7 (victim) 1. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included unspecified disorder of psychological development, lack of coordination, difficulty in walking, unqualified vision loss in the left eye, cerebral palsy, cerebellar ataxia (movement disorder, reduced mobility, dependence on a wheelchair, weakness and contracture of the right and left lower leg muscles. The 2/4/25 minimum data set (MDS) assessment documented Resident #7 had severe cognitive impairments with a brief interview of mental status (BIMS) score of seven out 15. The resident presented with inattention and disorganized thinking. The MDS assessment indicated Resident #7 did not exhibit verbal, physical or other behavioral symptoms directed towards others. He had upper extremity impairment to one side and lower extremity impairment to both sides. He used a manual wheelchair for mobility. 2. Record review The 3/10/25 alert note documented Resident #7 reported that another resident (Resident #3) pinched his leg. The note indicated the resident's left thigh was assessed and there was no redness, bruising or open areas identified. According to the note, Resident #7 said his leg no longer hurt but it did at the time of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/17/25 IDT (interdisciplinary team) note documented the IDT met and reviewed the physical aggression incident involving Resident #7. The note identified Resident #7 often sat in his wheelchair in his room doorway or in the hall near his room. He had some difficulty communicating with other residents which may have led to intermittent tension. Resident #7 was reminded to ask staff for help when needed and to keep the halls clear when possible. The note indicated the resident often blocked the hallway with his wheelchair while visiting with others. The IDT note indicated his care plan was updated. C. Resident #3 (assailant) 1. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included unspecified dementia, and specified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The 2/27/25 MDS assessment documented Resident #3 had severe cognitive impairments with a BIMS score of two out 15. The resident presented with inattention and disorganized thinking. According to the MDS assessment, she did not have an upper extremity impairment and was able to propel her manual wheelchair for short and long distances. The MDS assessment indicated Resident #3 had physical and verbal behavioral symptoms directed at others. The MDS assessment identified her behaviors impacted others and put them at risk for physical injury. 2. Record review The behavior care plan, initiated 3/17/25, revealed Resident #3 may become physically and/or verbally aggressive towards staff and others due to poor impulse control, dementia and history of harm to others. The care plan identified Resident #3 could be physically aggressive towards others, usually due to sundowning (increased confusion later in day and or evening). According to the care plan, staff should attempt to redirect the behavior. The 3/10/25 alert note for Resident #3 documented there was a witnessed physical altercation between Resident #3 and Resident #7 on 3/10/25. According to the note, the CNA asked the resident to apologize after Resident #3 pinched Resident #7 on the leg. Resident #3 apologized and then Resident #3 was assisted to her room. The 3/20/25 interdisciplinary note (IDT) note documented Resident #3 lacked impulse control, experienced cognitive decline related to disease process and required frequent redirection during episodes of verbal and physical aggression. D. Additional resident interview (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 was interviewed on 4/1/25 at 11:12 a.m. She said there was a resident who yelled all the time in the dining room. She said recently the resident entered her room and started yelling at her. Resident #11 identified the resident as Resident #3. Resident #11 said staff were aware that Resident #3 was yelling at her in her room. III. Allegation of sexual abuse between Resident #8 and Resident #3 on 3/16/25 A. Facility investigation A request was made for the facility's investigation after an allegation of sexual abuse was documented in Resident #3 progress notes on 3/16/25 (see record review below). -The facility was unable to provide documentation indicating the sexual abuse allegation documented in Resident #3's electronic medical record (EMR) was investigated. B. Resident #8 (victim) 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included Parkinson's disease without dyskinesia, anxiety disorder, major depressive disorder, abnormalities of the gate and mobility, weakness and unsteadiness on his feet. The 2/12/25 MDS assessment documented Resident #8 was cognitively intact with a BIMS score of 13 out of 15. He required partial to moderate staff assistance with transfers from surface to surface and bed mobility. He used a manual wheelchair for mobility. Resident #8 did not exhibit behaviors directed at others. 2. Resident #8 interview Resident #8 was interviewed on 4/2/25 at 1:58 p.m. Resident #8 said Resident #3 was sitting next to him in an activity on 3/16/25 when she put her hand under his shirt. Resident #8 said Resident #3 put her hand in the sleeve of his t-shirt and proceeded to move her hand down his shirt and up against his side by his ribs. Resident #8 said Resident #3 started to move her fingers in a tapping fashion. He said he told her to stop but she continued even after he told her to stop. He said Resident #3 continued to touch him in this manner for a couple minutes until the staff came over and stopped it. Resident #8 said the incident made him very uncomfortable. He said he felt Resident #3 was inappropriate towards him. He said he did not want to be around her and it would be uncomfortable if he was near her again. Resident #8 said Resident #3 came into his room last night (4/1/25) and was sitting by his bathroom until the staff removed her. He said he was very wary of doing anything because she had touched him before. He said he had also seen that she had very aggressive behaviors and hit and pounded on things with her fists. 3. Record review The trauma care plan, initiated 5/6/24, identified Resident #8 was at risk for side effects of trauma. The 5/22/24 intervention directed staff to draw connections among the resident's history of trauma and subsequent consequences. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #8's progress notes did not identify documentation of the 3/16/25 incident or facility follow-up with Resident #8 after the incident. C. Resident #3 (assailant) 1. Record review The depression care plan intervention for Resident #3, initiated 1/28/25, directed staff to track her sexually inappropriate behaviors. The psycho-social care plan, revised 1/20/25, identified Resident #3 was semi-dependent on staff for meeting her emotional, intellectual, physical, spiritual and social needs. According to the care plan, Resident #3 could be very sexually inappropriate. The 1/31/25 care plan invention directed staff to draw boundaries, redirect her hands, offer her a task to help and redirect her to a conversation so she could have safe interactions with others. The review of Resident #3's progress notes identified the resident had multiple incidents of sexually inappropriate behaviors, including touching staff inappropriately, between 1/29/25 and 3/15/25. The 3/16/25 behavior note documented Resident #3 was observed touching another resident inappropriately. According to the note, the other resident (Resident #8) reported that Resident #3 stroked his arm and side. When Resident #8 asked her to stop, she responded with you know you like it. The note indicated Resident #3 was then redirected with an activity. -However, the facility did not investigate Resident #3's sexually inappropriate behavior towards Resident #8 on 3/16/25. D. Other resident interviews Resident #12 and Resident #13 were interviewed together on 4/1/25 at 11:25 a.m. Resident #12 said there was a resident that was always yelling. Resident #12 said resident would pinch other residents. Both Resident #12 and Resident #13 denied being touched by Resident #3 but said they had seen it happen to other people. They said the other resident inappropriately touched staff and other residents. IV. Staff interviews Registered nurse (RN) #2 was interviewed on 4/1/25 at 4:40 p.m. RN #2 said Resident #3 had a history of inappropriate sexual behaviors but it was usually directed at staff. She said she was not aware of incidents involving other residents. She said Resident #3 was difficult to redirect after her inappropriate sexual behaviors because Resident #3 did not think her behavior was wrong. RN #2 said Resident #3's representative said she had inappropriate sexual behaviors since she was diagnosed with dementia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #3 was interviewed on 4/2/25 at 9:30 a.m. CNA #3 said Resident #3 was pretty calm and was easier to redirect and more cognizant in the mornings. She said her behaviors usually increased after 2:00 p.m. and she was harder to redirect. She said Resident #3 had physical and sexual behaviors. CNA #3 said Resident #3 had sexual behaviors directed toward staff and residents. She said she had not seen the sexual behavior towards residents herself but had been told it was a behavior. She said Resident #3 did not target one particular resident. She said when Resident #3 had inappropriate behaviors, staff would separate them and would try to redirect Resident #3 to an activity. The nursing home administrator (NHA) was interviewed on 4/2/25 at 10:25 a.m. The NHA said abuse prevention started with making sure staff was appropriately trained to help prevent abuse occurrences. He said all potential abuse allegations should be investigated and reported. The NHA was interviewed again on 4/2/25 at 12:02 p.m. The NHA said the 3/16/25 incident between Resident #3 and Resident #8 was investigated by the nurse manager (NM). The NHA said the incident did not rise to the level of abuse because Resident #8 said Resident #3 just touched his arm. -However, Resident #8 said Resident #3 put her hand under Resident #8's shirt (see Resident #8's interview above). The NM was interviewed on 4/2/25 at 12:20 p.m. The NM said she was the nurse manager a few days a week. She said if an incident occurred on her weekend shift, she would make sure the floor nurse documented the incident in a note and would look at the risk management process. The NM said on 3/16/25 the floor nurse, licensed practical nurse (LPN) #3 reported to her that another staff member told LPN #3 they either witnessed or heard that Resident #3 touched Resident #8 and Resident #3 was told to stop. The NM said LPN #3 spoke to Resident #8 after the incident. She said LPN #3 told her Resident #8 said Resident #3 was touching his arm, he told her to stop and Resident #3 asked him if he liked it. The NM said her role related to the investigation was to talk to LPN #3, direct her to write a progress note and report the incident to the DON. The NM said she completed no documentation and was not involved in any other part of the investigation. The NM said she did not usually do anymore in an investigation other than just oversight of the situation when she was the nurse manager on duty. She said the DON or the NHA did the full investigation. The social services designee (SSD) was interviewed on 4/2/25 at 10:30 a.m. The SSD said she had not been part of any investigations but was aware of Resident #3's inappropriate sexual behaviors toward staff. She said she was not aware of any incidents involving residents. She said Resident #3 tended to reach out and grab staff inappropriately. The SSD said she had displayed as many sexual behaviors in the past month since she was admitted to hospice services. She said the staff had been instructed to hold her hand when she tried to reach for them. She said she felt Resident #3 just needed a human touch. She said Resident #3's family decided they were going to move her closer to other family members to help with her behaviors, but the family and the facility had had difficulty finding another facility because of Resident #3's behaviors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 4/2/25 at 12:51 p.m. She said allegations of abuse should be reported to the nurse, nurse leadership, including the DON, and the NHA should be alerted. She said the facility talked with staff and to find out what happened. The DON said if the incident was an abuse allegation, it should be reported to the State Agency within 24 hours. She said a reportable sexual abuse allegation would be reported if it was determined that there was a inappropriate touch to a resident and if the resident who was touch did not consent. The DON said non-consentual touch could be considered sexual abuse. She said if a resident touched another resident and indicated it was not welcomed by words, such as no or do not touch me, it could be considered sexual abuse. The DON said she did not have the investigation for the 3/16/25 investigation involving Resident #3 and Resident #8 but the NHA might have it. She said the NM spoke to LPN #3, Resident #3 and Resident #8 after the incident. The DON said a risk management report should have been completed after the 3/16/25 incident but she could not find one. The DON said, based on what Resident #8 reported the NM, she felt that the 3/16/25 incident was not an allegation of sexual abuse because there was not a concern of sexual contact. She said she could assume that was why a risk management report was not done. The DON said when there was a allegation of sexual abuse, the staff would review the resident's chart to look for similar behaviors. She said Resident #3 had a history of sexual behaviors towards staff. The DON said the physician was aware of the behaviors. She said the behaviors were tracked and reviewed in IDT and the medication review meeting. Physician (PHY) #1 was interviewed on 4/2/25 at 2:55 p.m. PHY #1 said she was the physician for Resident #3. She said during her rounds at the facility, she was told Resident #3 was inappropriate with another resident (Resident #8). She said the incident was reported to her one to two days after the incident occurred. She said she was not told what happened so she reviewed the chart and learned Resident #3 touched a male resident's arm and chest in his room and staff had to remove her. PHY #1 said she was told Resident #3 pinched the leg of another resident. She said anytime there was a new behavior, she and the facility would assess the behavior and the facility would update the care plan. PHY #1 said she would make recommendations. She said it was determined to continue Resident #3 with her current medications because hypersexual behavior was a normal behavior and could be expected with Alzheimer's dementia. The DON was interviewed again on 4/2/25 at 3:47 p.m. The DON said she reviewed the available documentation and the facility did not have an investigation for the 3/16/25 incident between Resident #3 and Resident #8. The NHA was interviewed again on 4/2/25 at 4:25 p.m. The NHA said after Resident #3 pinched Resident #7, the facility did a risk management review and felt the incident did not rise to the level of abuse. He said the pinching did occur but there was no potential for harm. The NHA said Resident #7 said ouch when he was pinched. He said the resident may have said ouch out of a response to the pinching but it might not have indicated he was in pain. The NHA said an investigation was not documented for the 3/16/25 incident between Resident #3 and Resident #8. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52513 Based on observations, record review and interviews, the facility failed to consistently provide catheter care, treatment and services to minimize the risk of urinary tract infections for one (#2) of three residents reviewed for catheter care out of 13 sample residents. Specifically, the facility failed to: -Ensure staff provided appropriate catheter care for Resident #2, who had a history of recurring urinary tract infections (UTI); and, -Ensure Resident #2's baseline care plan included catheter care for his indwelling Foley catheter. Findings include: I. Facility policy and procedure The Catheter Care policy, revised August 2022, was provided by the director of nursing (DON) on 4/2/25 at 5:40 p.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from the insertion site to approximately four inches outward. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included stroke affecting the right dominant side, neuromuscular dysfunction of the bladder, sepsis and type 2 diabetes. The 2/25/25 minimum data set (MDS) assessment revealed that the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) score of nine out of 15. He was dependent with toileting, bathing, dressing, and personal hygiene. He required assistance with setup to eat and complete oral hygiene. B. Observation (continued on next page)

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	065307	A. Building B. Wing	04/02/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 11:34 a.m. Resident #2's incontinence care was observed. Certified nurse aides (CNA) #1 and CNA #2 entered the resident's room to provide care. CNA #2 assisted the resident onto his side while CNA #1 cleaned the resident following an episode of bowel incontinence. -During the incontinence care, CNA #1 did not clean the resident's indwelling catheter or the catheter's insertion site, despite the fact that Resident #2 had been incontinent of bowel. C. Resident and resident representative interviews Resident #2 was interviewed on 4/1/25 at 10:02 a.m. Resident #2 said staff cleaned his catheter sometimes, but he said staff did not clean his catheter daily. Resident #2's representative was interviewed on 4/1/25 at 2:46 p.m. The resident's representative said she attended a care conference with the facility and the hospice agency on 3/18/25. She said they discussed the provision of hygiene assistance because she was concerned that the facility was not providing Resident #2 sufficient hygiene assistance and she was concerned that he had another UTI due to lack of consistent catheter care. The representative said Resident #2 had occasionally refused care, so she was not sure how they ensured proper catheter care was being completed for the resident. D. Record review The history and physical exam, completed 2/20/25, indicated the clinical justification for Resident #2's indwelling catheter was for neurogenic bladder dysfunction after suffering a stroke and failed voiding trials in the hospital prior to his admission to the facility. The exam indicated the resident had an indwelling catheter on admission to the facility that had clear yellow urine without discharge. The physician recommended continued management of the indwelling catheter in the admission assessment. -However, Resident #2's baseline care plan failed to document a care plan focus to address the care of the resident's indwelling catheter within 48 hours after the resident's admission to the facility. Review of Resident #2's comprehensive care plan, initiated 3/2/25, revealed the resident had an impaired urinary elimination pattern due to a neurogenic bladder diagnosis. Interventions included providing indwelling catheter care each shift and as needed and securing the catheter with a securement device without pulling on the catheter. -However, the facility did not provide catheter care as needed appropriately after bowel incontinence (see observation above). -Additionally, per the hospice registered nurse's (HRN) 3/9/25, nursing note, the securement device for the catheter was placed incorrectly (see note below). -Review of Resident #2's March 2025 treatment administration record (TAR) did not document a physician's order for catheter care until 3/2/25, 12 days after the resident's admission to the facility. (continued on next page)

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