

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Mantey Heights Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on record review and interviews, the facility failed to ensure was kept free from physical abuse for one (#4) of five residents reviewed for abuse out of six sample residents. Specifically, the facility failed to protect Resident #4 from physical abuse by Resident #5. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation and Misappropriation Prevention policy, revised April 2021, was provided by the director of nursing (DON) on 7/20/26 at 4:10 p.m. The policy revealed, The residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents symptoms. The resident abuse neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives. Protect the resident from abuse, neglect, exploitation, or misappropriation of property by anyone including but not necessarily limited to facility staff and or other residents. Develop and implement policies and protocols to prevent identity abuse. Ensure adequate staffing and oversight. Conduct employee background checks. Establish and maintain the culture of compassion and care for all residents and particularly those with behavioral, cognitive or emotional problems. II. Incident of physical abuse by Resident #5 towards Resident #4 on 6/20/26 A. Facility investigation The 6/22/26 facility investigation, documented at 2:40 p.m., revealed Resident #4 and Resident #5 had a physical altercation on 6/20/26. A verbal altercation started when Resident #4 accused Resident #5 of taking a radio. Resident #5 became upset with the allegation and Resident #5 pushed Resident #4 in the chest. Both residents lost their balance and fell to the ground. The altercation was witnessed by another resident (Resident #9) who notified staff of the incident. The residents were immediately separated and assessed for any injuries. No injuries were reported. Both residents were placed on every 15-minute safety checks (staff to monitor the whereabouts of each resident) and to keep them separated from each other. The abuse investigation was started. The residents' representatives, providers and the ombudsman were notified. Both residents were interviewed by the DON on 6/22/26 and both residents reported they were verbally and physically abusive to one another. The resident who witnessed the altercation between Resident #4 and Resident #5 was interviewed by the DON on 6/22/26 and the resident confirmed the interaction started with a verbal exchange, which led to physical contact between the two residents. The next day after the altercation (on 6/21/26), Resident #4 was sent to the hospital for an evaluation for rib and chest pain. All diagnostics were negative for fractures and the resident returned to the facility the same day. The final diagnosis from the hospital was a chest contusion. The physical abuse investigation concluded the abuse between Resident #4 and Resident #5 did happen, based on the residents' reports and the witness statement. The facility (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065307 If continuation sheet Page 1 of 4

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantiated the abuse.B. Resident #4 (victim)1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the July 2026 computerized physician orders (CPO), diagnoses dementia of unspecified severity with agitation, chronic obstructive pulmonary disease (COPD) and diabetes. According to the 5/19/26 minimum data set (MDS) assessment, the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. The resident was independent with activities of daily living (ADL) for ambulating, eating and dressing, and hygiene. The assessment indicated the resident had behavioral symptoms directed towards others, (threatening, screaming and cursing) which occurred one to three days a week during the assessment look-back period. 2. Record reviewThe nurse note, dated 6/20/26 at 10:58 p.m., documented a certified nurse aide (CNA) communicated to the nurse that Resident #9 had witnessed a physical aggression incident between Resident #4 and Resident #5 and reported this to the CNA. Resident #4 and Resident #5 were assessed and Resident #4 complained of back pain.The nurse note, dated 6/21/26 at 7:21 a.m., documented Resident #4 continued to request more pain medications related to his back pain, which he rated as a 10 out of 10 on a pain scale of 1-10. The resident was offered an ice pack but refused, and demanded more pain medications. The nurse note, dated 6/21/2026 at 4:12 p.m., documented Resident #4 had altered mental status related to uncontrolled pain. It was recommended to transfer the resident to the hospital for an evaluation. The provider note, dated 6/21/26 at 5:21 p.m., documented Resident #4 was in a resident-to-resident altercation and staff reported the resident had had a change in mentation since the altercation. Resident #4 was now unable to walk straight, was leaning to the left side and reported an increase in pain. Resident #4 declined to have an Xray at the facility and requested to go to the hospital for an evaluation. The nurse note, dated 6/21/26 at 6:35p.m., documented Resident #4 was transferred to the hospital for complaints of pain. The nurse note, dated 6/21/26 at 7:49 p.m., documented Resident #4 returned from the hospital with a diagnosis of a chest wall contusion (bruising). The interdisciplinary at risk note, dated 6/22/26 at 9:32 a.m., documented Resident #4 was engaged in a verbal altercation with Resident #5, which resulted in Resident #4 being punched in the chest by Resident #5. The root cause was from Resident #4 making an accusation and engaging in antagonistic behaviors toward Resident #5. Current interventions for Resident #4 were to analyzing key times, places, triggers and what de-escalated the resident's behaviors, offering for the resident to fold linens when experiencing anxiety, monitoring and documenting circumstances surrounding verbal abusive behaviors to determine the cause and removing the cause when possible, offering snacks and fluids when visibly distressed, validating the resident's feelings when agitated and intervening when agitation escalated and guiding the resident away from the source of distress and discharge planning for the most appropriate placement to meet the resident's psychosocial and cognitive needs. Resident #4's behavior care plan, revised 3/25/26, revealed Resident #4 often threatened to leave the community when he was told he was out of cigarettes or money. When he had anxiety and agitation, he often paced the community hallways. There were days the resident could become verbally agitated towards others. Interventions included immediately separating residents if they engaged in unreciprocated physical behavior, offering for the resident to assist with folding linens when he was experiencing anxiety, monitoring for and reporting to management immediately any episodes of the resident engaging in unreciprocated physical affection, monitoring and documenting the circumstances surrounding the resident's verbally abusive behavior, attempting to determine the pattern or cause of behaviors, and where possible, altering or removing the cause, offering snacks and fluids when the resident was visibly distressed, specifically sweet treats and decaffeinated coffee, when the resident became agitated, intervening before the agitation escalated and guiding the resident away from the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	source of distress, and engaging calmly in conversation, if the resident's response was aggressive, staff was to walk calmly away and approach later. C. Resident #5 (assailant)1. Resident statusResident #5, age less than 65, was admitted on [DATE]. According to the July 2026 CPO, diagnoses included dementia of unspecified severity without behavioral disturbances, schizophrenia with psychotic disturbances and COPD.According to the 4/10/26 MDS assessment, the resident was moderately cognitively impaired with a BIMS score of 12 out of 15. The resident was independent with ADLs. The assessment indicated the resident had no behaviors.2. Resident interviewResident #5 was interviewed on 7/20/26 at 1:35 p.m. Resident #5 said Resident #4 accused him of taking his things. Resident #5 said he did not like when people accused him of taking things. He said he got mad and pushed Resident #4 and then Resident #4 pushed him and both of them fell to the ground. He said he always tried to stay away from Resident #4 but on that day (6/20/26), Resident #4 was too close to him. He said he was not mad anymore and he felt safe around Resident #4. 3. Record reviewThe nurse note, dated 6/20/26 at 3:53 p.m., documented Resident #5 had an altercation with Resident #4 where Resident #5 punched Resident #4 in the chest. An assessment was completed and no injuries were noted. Staff were monitoring both residents with 15-minute checks. The provider note, dated 6/21/26 at 3:55 p.m., documented Resident #4 and Resident #5 were involved in a physical altercation, which was witnessed by Resident #9. Resident #5 pushed and shoved Resident #4 in the chest and both residents fell backwards. Staff reported the residents' had been separated and placed on every 15-minute safety checks. The interdisciplinary at risk note, dated 6/22/26 at 9:30 a.m., documented Resident #5 was engaged in a verbal altercation with Resident #4, which resulted in Resident #4 being punched in the chest by Resident #5. The root cause was Resident #5 became agitated after Resident #4 engaged in accusatory statements. Current interventions for Resident #5 were to assess the residents' understanding of the situation and allow time for the resident to express his feelings, analyzing key times, places, triggers and what de-escalated the behaviors and documenting and assessing the resident's coping skills and support system with a plan for success. Resident #5's behavior care plan, dated 6/23/26, revealed Resident #5 had safety concerns due to physical aggression. The resident had a history of becoming physically aggressive toward others when feeling antagonized. Resident #5's triggers were feeling tense and threatened. Interventions included continuing to support the resident in identifying coping strategies when he felt tense, overwhelmed or threatened, supporting the resident by providing reminders and assistance to schedule and attend follow-up behavioral health appointments as needed, analyzing key times, places, circumstances, triggers, and what de-escalated behavior and documenting, assessing resident's coping skills and support system, assessing the resident's understanding of the situation, allowing time for the resident to express himself and his feelings towards the situation and planning for success. III. Staff interviewsCNA #1 was interviewed on 7/20/26 at 1:15 p.m. CNA #1 said there was an altercation between Resident #4 and Resident #5 on 6/20/26. She said she was working that day and was told about the incident. She said Resident #4 was always in other residents' space, accusing residents of taking his things. She said according to Resident #9, both Resident #4 and Resident #5 were verbally aggressive toward each other and a physical fight broke out. She said since the altercation, the two residents had stayed away from each other and staff monitored to keep them separated. CNA #1 said the residents lived in separate hallways. She said Resident #5 was not aggressive unless someone provoked him. She said Resident #4 had behaviors with aggression toward staff and other residents. CNA #2 was interviewed on 7/20/26 at 1:20 p.m. CNA #2 said both Resident #4 and Resident #5 were independent and walked around the hallways during the day. She said she worked the day of the incident (6/20/26) and was informed that both residents were verbally aggressive toward each other, (continued on next page)		

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