STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065347	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health Care Center, Inc	2120 N 10th St Canon City, CO 81212

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 - Some	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 observations, record review and interviews, the facility failed to ensure that all residents were free from abuse, neglect and exploitation for six (#1, #4, #3, #2, #8 and #7) of eight residents reviewed out of 13 sample residents. Specifically, the facility failed to: -Protect Resident #1 from physical abuse by Resident #8; -Protect Resident #4 from physical abuse by Resident #9; -Protect Resident #3 and Resident #8 from physical abuse by each other; -Protect Resident #2 from physical abuse by Resident #10; and, -Protect Resident #7 and Resident #8 from physical abuse by each other. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/4/25 at 10:57 a.m. The policy read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent abuse by anyone. Residents have the right to be free from abuse. Providing a safe environment for the resident was an essential duty of the facility. Residents at risk for abusive situations are identified, and appropriate care plans are developed. II. Incident of physical abuse on 4/16/25 by Resident #8 towards Resident #1 A. Facility investigation (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/16/25 facility investigation was received from the NHA on 6/2/25 at 1:15 p.m. The investigation documented Resident #1 sat on his walker in the hallway and began to back up, almost running into Resident #8. Resident #8 reached out and hit Resident #1 with his arm in the middle of his back. The investigation documented facility staff responded to the altercation and separated the residents. The nurse completed an assessment on both residents and documented Resident #1 and Resident #8 had no changes in behavior and had no injuries. The investigation included interviews with Resident #1 and Resident #8. The facility investigation documented Resident #1 said there was no incident and no one had been abusive towards him. The facility investigation documented Resident #8 said nothing happened with Resident #1. The facility substantiated physical abuse by Resident #8 towards Resident #1. B. Resident #8 (assailant) 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician's orders (CPO), diagnoses included dementia with behavioral disturbance and Wernicke's encephalopathy (a neurological condition that can impact balance and cause confusion). The 3/11/25 minimum data set (MDS) assessment revealed the resident had severely impaired cognition with a brief interview for mental status (BIMS) score of zero out of 15. Resident #8 required set-up assistance from staff for standing and was independent with walking. The MDS assessment documented the resident had physical and behavioral symptoms directed towards others during the assessment look back period. 2. Record review The care plan, revised 3/27/25, revealed Resident #8 could become physically aggressive by striking out at others. The care plan documented potential triggers for Resident #8 included disagreements or confrontations with others and people invading his personal space. The care plan identified additional triggers on 3/10/25 to include prolonged waiting for the opening of the dining room for meals. Pertinent interventions included providing physical and verbal cues to alleviate anxiety (initiated 3/10/25), assisting the resident with goals for pleasant behavior (initiated 3/10/25), encouraging the resident to seek a staff member when agitated (initiated 3/10/25) providing support to Resident #8 if other residents were invading his personal space (initiated 4/21/25), offering non-pharmological interventions such as offering food, drinks or an activity of choice (initiated 4/21/25). The care plan directed staff to de-escalate the resident's behavior by reducing wait times, listening to music and watching western television shows (initiated 3/10/25). Review of Resident #8's electronic medical review (EMR) revealed Resident #8 was monitored for 72 hours after the altercation and no additional behaviors were documented. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #1 (victim) 1. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included disorganized dementia, obsessive-compulsive disorder, anxiety and difficulty walking. The 3/20/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. Resident #1 required set-up assistance from staff for standing and walking. Resident #1 used a rolling walker with a seat while walking. The MDS assessment indicated the resident did not have behavioral symptoms directed towards others during the assessment look back period. 2. Resident interview Resident #1 was interviewed on 6/2/25 at 2:44 p.m. Resident #1 said he remembered when he was hit on the back by Resident #8. He said Resident #8 hurt him on the back. Resident #1 said he was doing fine now and was not afraid. Resident #1 said he did not know Resident #8 was standing behind him when he pushed his walker backward and he was not angry at Resident #8. 3. Record review The behavior care plan, revised 4/21/25, identified Resident #1 had a behavior pattern of yelling that had the potential to trigger and disrupt other residents to respond with agitation towards Resident #1. Interventions included anticipating and meeting the residents needs, assisting and developing appropriate methods of coping and redirecting Resident #1 from other residents during times of disruptive and yelling behavior. III. Incident of physical abuse on 4/27/25 by Resident #9 towards Resident #4 A. Facility investigation The 4/27/25 facility investigation was received from the NHA on 6/2/25 at 1:15 p.m. The investigation documented the facility reviewed video cameras from 4/27/25 at 2:10 p.m. The video revealed Resident #9 moved down the left side of the hallway towards his room. Resident #4 was observed self-propelling his wheelchair, traveling in the opposite direction of Resident #9. Resident #4 propelled himself past Resident #9's doorway. Resident #9 turned towards Resident #4 and struck him with his fist, hitting Resident #4 in the face and then went into his room. The video summary documented that staff members arrived in the hallway and assisted Resident #4 to move away from Resident #9's doorway. The investigation documented the nurse completed an assessment on both residents and documented Resident #4 and Resident #9 had no changes in behavior and had no injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation included interviews with Resident #4 and Resident #9 on 4/28/25. The facility investigation documented Resident #4 said he did not know what the investigator was talking about. Resident #4 denied being involved in an altercation with anyone. The facility investigator interviewed Resident #9, who did not respond to questions and denied he was in an altercation. The facility substantiated physical abuse by Resident #9 towards Resident #4. B. Resident #9 (assailant) 1. Resident status Resident #9, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included schizophrenia (mental illness), traumatic brain injury and cognitive communication deficit. The 5/28/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #9 was independent with standing and walking. The MDS assessment documented the resident had no physical or verbal behaviors directed at others during the assessment look back period. 2. Record review The behavioral care plan, revised 3/10/25, identified Resident #9 had the potential to be physically aggressive, including hitting, kicking, pushing and grabbing others The resident had a history of causing harm to others and had poor impulse control. The care plan documented aggression was triggered when others entered Resident #9's room or followed too closely behind him. Pertinent interventions included administering medications ordered, assessing and anticipating Resident #9's needs, encouraging Resident #9 to seek a staff member when agitated, giving Resident #9 choices about his care and activities, redirecting other residents when others became too close to Resident #9 and when Resident #9 was agitated and intervening before agitation escalated. An additional intervention, implemented 5/7/25, directed staff to redirect others from Resident #9 in an attempt to decrease physically aggressive behaviors. The 4/27/25 nurse progress note documented that as Resident #9 was walking to his room, he hit Resident #4. The note documented Resident #4 held his hands up in a defensive manner. The camera footage showed Resident #9 hit Resident #4 on the head three times. A head to toe assessment was completed by the registered nurse (RN) and no injuries or bruises were present. On 5/30/25 the physician ordered an increase in Resident #9's antidepressant medication, Trazadone, to 75 milligrams (mg) four times a day, for impulsiveness and physical aggression behaviors. C. Resident #4 (victim) 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included dementia, anoxic brain damage and mood disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/28/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #4 required partial to moderate assistance from staff to stand and sit and substantial assistance from staff to propel a manual wheelchair. The MDS assessment indicated the resident had no behaviors directed towards others during the assessment look back period. 2. Record review The behavioral care plan, initiated 3/10/25, revealed Resident #4 could become verbally aggressive and lash out at others if agitated. Interventions included administering medications as ordered, monitoring Resident #4 and intervening and redirecting when agitated to prevent escalation. IV. Altercation on 4/28/25 between Resident #8 and Resident #3 A. Facility investigation The 4/28/25 facility investigation was received from the NHA on 6/2/25 at 1:15 p.m. The investigation documented the facility reviewed video footage from 4/28/25 at 7:30 p.m. The video revealed Resident #3 and Resident #8 were in the hallway. When Resident #3 walked towards Resident #8, Resident #8 stood up and moved towards Resident #3, hitting Resident #3 multiple times. The footage showed Resident #3 hit the aggressor back after the assailant hit him a couple of times. The facility investigation documented staff responded from inside another resident's room and separated Resident #3 and Resident #8. The investigation documented the nurse completed an assessment on both residents and documented Resident #3 and Resident #8 had no changes in behavior and had no injuries. The facility investigation included interviews with Resident #3 and Resident #8 that were completed on 4/29/25 The facility investigation documented Resident #3 said he did not know why Resident #8 was mad at him. The investigation documented Resident #8 told the facility investigator that Resident #3 said inappropriate things repeatedly, and he hit Resident #3 so he would stop talking inappropriately. The facility investigator interviewed one staff member that reported he heard Resident #3 say explicit language to another resident. The staff member told the facility investigator he went to investigate and observed Resident #3 and Resident #8 in a fistfight and separated the residents. The facility substantiated physical abuse by Resident #8 towards Resident #3. B. Resident #8 (assailant and victim) 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's EMR revealed Resident #8 were placed on 15-minute checks until evaluated by the physician, and no additional behaviors were documented. On 5/2/25 the physician evaluated Resident #8 and frequent monitoring was discontinued. C. Resident #3 (victim and assailant) 1. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included disorganized dementia, schizophrenia, history of traumatic brain injury and encephalopathy (a brain condition that can cause impaired memory, behavior and level of consciousness). The 4/23/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. Resident #3 was independent with standing and walking. The MDS assessment indicated Resident #3 did not have behaviors directed at others during the assessment look back period. 2. Record review The behavior care plan, revised 9/18/24, revealed Resident #3 had the potential to be verbally aggressive due to dementia. Interventions included providing Resident #3 with choices for care and activities and providing the resident time to respond to staff, administering medications as ordered and redirecting other residents away from Resident #3 if Resident #3 was agitated. The 4/28/24 nurse progress note documented Resident #3 was walking toward another resident and the other resident got up and hit Resident #3 multiple times. The record review revealed, on 4/28/25, Resident #3 was placed on 15-minute checks for 72 hours and no additional behaviors were documented. V. Altercation on 5/5/25 between Resident #10 and Resident #2 A. Facility investigation The 5/5/25 facility investigation was received from the NHA on 6/2/25 at 1:15 p.m. The investigation documented the facility reviewed video footage from 5/5/25 at 6:30 p.m. The video footage revealed Resident #2 was walking in the hallway and approached Resident #10's doorway. Resident #10 was walking through the doorway and approached Resident #2. Resident #10 pushed Resident #2 with his arm. Resident #2 was observed to lose her balance and grab onto Resident #10. Resident #10 then pushed Resident #2, causing her to fall backward onto her elbow and wrist. The investigation documented that staff came around the hallway and immediately separated the residents. The facility investigation documented the nurse completed an assessment on 5/525 and contacted the physician to report that Resident #2 had pain in her wrist and elbow. The physician ordered Xrays of Resident #2's wrist and elbow which showed no acute fractures. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation documented Resident #10 was placed on one-to-one monitoring when he was outside of his room and 15-minute checks while in his room to prevent additional aggression for 72 hours. The facility investigation documented interviews with Resident #2 and Resident #10 on 5/5/25. The facility investigator documented that Resident #2 said she did not remember the altercation and told the investigator she was not fearful of anyone in the facility. The facility investigation documented Resident #10 told the facility investigator the altercation occurred because Resident #2 was in his room. The facility substantiated physical abuse by Resident #10 towards Resident #2. B. Resident #10 (assailant) 1. Resident status Resident #10, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included Wernicke's encephalopathy and history of traumatic brain injury. The 5/30/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. Resident #10 was independent with standing and walking. The MDS assessment indicated the resident had no behavioral symptoms directed at others during the assessment look back period. 2. Record review The behavioral care plan, revised 3/6/25, documented Resident #10 had challenges with impulse control and may act out physically by lashing out at others due to poor impulse control, which could lead to violent outbursts in the form of hitting, kicking and pushing. Interventions included assisting Resident #10 with appropriate methods of coping when a resident entered his room, intervening as necessary to protect the rights and safety of others, removing individuals from the situation and relocating them to alternative locations as needed, educating Resident #10 about the consequences of being physically aggressive, identifying what de-escalateed behavior and intervening when the resident became agitated to prevent escalations and guide Resident #10 away from the source of distress. The behavioral care plan, revised 4/24/25, was updated with an additional intervention for educating Resident #10 to ask for assistance from staff if another resident was being aggressive with him. The 5/5/25 nurse progress note documented Resident #10 used his forearm to push another resident (Resident #2) and was waving his arms and yelling. The behavioral care plan, updated 5/5/25, included the intervention for one-on-one monitoring while Resident #10 was outside his room and 15-minute monitoring while in the room. C. Resident #2 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included Alzheimer's disease and dementia. The 4/29/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. Resident #2 was independent with standing and walking. The MDS assessment indicated the resident had behavioral symptoms directed towards others during the assessment look backperiod. 2. Observations On 6/4/25 at 2:30 p.m, Resident #2 was entering a resident's room and removing a stack of papers. Resident #2 wandered in the hallway with the papers for approximately five minutes and another resident assisted Resident #2 to return the papers. There were no facility staff present in the hallway. 3. Record review The behavioral care plan, initiated 8/8/24 and revised 5/5/25, identified Resident #2 had wandering behavior with a history of entering the rooms of other residents without invitation or awareness. Pertinent interventions included redirecting Resident #2 to familiar hallways and to the dining room area where she visited with her spouse and redirecting Resident #2 away from Resident #10 due to past aggression. The 5/5/25 nurse progress note documented Resident #2 was walking in the hallway and stopped and looked into Resident #10's room. Resident #10 came from his room and used his forearm to push Resident #2 and Resident #2 fell to the floor. The physician was contacted and gave an order for Xrays of Resident #2's right wrist and right elbow. VI. Altercation on 5/17/25 between Resident #8 and Resident #7 A. Facility investigation The 5/17/25 facility investigation was received from the NHA on 6/5/25 at 12:10 p.m. The investigation documented the facility reviewed video footage from 5/17/25 at 6:05 p.m. The video footage revealed Resident #7 and Resident #8 were standing next to each other in the hallway by the nurses'station. Resident #7 and Resident #8 exchanged words, Resident #8 approached Resident #7, reaching out and grabbing Resident #7's clothing. Resident #7 grabbed Resident #8's arms and pushed Resident #8 away from him. Resident #7 stumbled and fell backward to the floor. The investigation report documented the nurse completed an assessment on 5/5/25 and contacted the physician to report the occurrence and that Resident #7 had pain near his left hip and low back. The physician ordered a left hip Xray which showed no fracture. The investigation documented Resident #8 was placed on one-to-one monitoring when he was outside of his room and 15-minute checks while in his room to prevent additional aggression for 72 hours. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation documented interviews were conducted with Resident #7 and Resident #8 on 5/17/25. The facility investigator documented Resident #7 said he was pushed to the floor by Resident #8 and Resident #8 called him names when he was on the floor. When the facility investigator interviewed Resident #8, he reported he did not remember anything. The facility investigation documented one staff member heard the altercation from inside the nurses' station and looked out into the hallway where he saw Resident #7 fall to the floor. The facility substantiated physical abuse by Resident #8 towards Resident #7. B. Resident #8 (assailant and victim) 1. Record review Review of Resident #8's EMR revealed that on 5/17/25, Resident #8 was placed on 15-minute checks until evaluated by the physician and no additional behaviors were documented. On 5/20/25 the physician evaluated Resident #8 and frequent monitoring was discontinued. On 5/20/25 the physician ordered an antipsychotic medication, Risperdal, 1 mg, twice a day for aggressive behaviors. C. Resident #7 (assailant and victim) 1. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included Alzheimer's disease, dementia, restlessness and agitation. The 5/16/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. Resident #7 was independent with standing and walking. The MDS assessment documented Resident #7 had no physical or verbal behaviors directed at others during the assessment look back period. 2. Record review The 5/17/25 at 6:30 a.m. nurse progress note documented Resident #7 fell to the floor after Resident #8 grabbed Resident #7's arm, which caused Resident #7 to fall to the floor. The physician was notified and gave orders for an Xray for the left hip and pelvis. The record review revealed, on 5/17/25, Resident #7 was placed on 15-minute checks for 72 hours for monitoring purposes. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavioral care plan, initiated 5/12/25, revealed Resident #7 had the potential to be verbally aggressive due to dementia and Alzheimer's disease. The resident had difficulty expressing his feelings and needs. The interventions included administering medications as ordered, assessing Resident #7's coping skills, allowing Resident #7 time to express himself and his feelings and giving Resident #7 as many choices as possible about his care and activities. VII. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/5/25 at 10:05 a.m. CNA #1 said she was assigned to provide care to residents on all of the hallways. She said CNAs were assigned to work on specific hallways but that she was a float CNA and helped on all of the hallways. CNA #1 said Resident #8, Resident #10 and Resident #9 had a history of physical and verbal behaviors towards staff and residents. CNA #1 said if a resident had increased agitation, staff redirected the resident to an activity such as listening to music or watching television. CNA #1 said that when CNAs provided care to residents it was possible there would be no staff members in the hallway to monitor residents in the hallways. CNA #1 said if a CNA was off the floor for a break or lunch or another reason, there were no coworkers assigned to monitor residents or the hallways. CNA #1 said staff helped each other but the hallways were not always monitored. CNA #1 said she had training related to things to watch for and intervene when residents had aggressive behaviors. She said she received training in abuse and de-escalation when hired and periodically during the year at staff meetings and during shift change reports. CNA #1 said Resident #8 exhibited spontaneous behaviors. She said the staff monitored and redirected Resident #8 when he acted aggressively. The social services director (SSD), the director of nursing (DON) and the NHA were interviewed together on 6/5/25 at 2:30 p.m. The SSD said Resident #8 had a history of physical and verbal aggression when others approached his space. The SSD said Resident #8 was spontaneous with behaviors and staff were unable to respond fast enough when Resident #8 had escalating behaviors. The SSD said Resident #8 had not had verbal or physical behaviors since the physician adjusted the resident's Risperdal medication on 5/20/25. The DON said when there was a resident-to-resident altercation, the charge nurse completed an assessment for each resident and notified the physician. The DON said after altercations, residents were placed on one-to-one care or 15-minute checks for close observation for injury or changes in behavior. The DON said Resident #1, Resident #7, Resident #4 and Resident #2 experienced pain from the altercations but had no injuries or changes in behaviors. The NHA said staff responded promptly to the altercations and redirected residents when necessary. The NHA said the facility had continuous video surveillance and recordings of the hallways and the display monitors were positioned inside the nurses'station. The NHA said the video cameras were in place and monitored by staff that worked inside the nurses'station. She said the video surveillance was not monitored continuously by a staff member, and the cameras were in use to help staff monitor all the hallways from the nurses'station when floor staff were helping other residents or were on a break. The NHA said the staff had been educated to not congregate in the breakrooms at the same time as coworkers and there should be staff on each hallway to care for residents and monitor behavior. (continued on next page)

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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 - Some	The NHA said Resident #2 wandered throughout the facility. The NHA said Resident #2 was entering fewer rooms. The NHA said the staff redirected Resident #2 to her hallway, the dining room and the activities area to avoid her entering rooms uninvited. The NHA said the interdisciplinary team (IDT) would continue to review and monitor Resident #2 for wandering behaviors.