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	09/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents at risk for elopement out of three sample residents received adequate supervision and were kept free from elopement.Specifically, the facility failed to provide Resident #1 with the supervision necessary to prevent elopement.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 9/10/25 to 9/11/25, resulting in the deficiency being cited as past noncompliance with a correction date of 9/8/25.I. Facility policy and procedure The Elopement and Wandering policy, dated 2/29/25, was received from the nursing home administrator (NHA) on 9/12/25 at 2:05 p.m. It revealed in pertinent part, To ensure the safety and well being of all residents with potential elopement risk. The goal of the facility is to provide a safe environment using least restrictive measures available in caring for residents who were exhibiting elopement behaviors. The facility defined wanderers as residents who moved around the facility in a non-goal directed manner, but did not make efforts to leave the premises. Elopers are defined as residents who make an overt or purposeful attempt to leave the facility and do not have the ability to identify safety risks. The elopement policy and procedure shall be explained to the resident or the responsible party as needed by a facility staff member. A Wander/Elopement assessment will be completed on all residents upon admission to the facility. The outcome is shared with the interdisciplinary team during the initial care conference, or earlier if the elopement risk is of immediate concern. The elopement risk is assessed quarterly or as needed with change of condition. Nursing staff will address initial elopement risk concerns in the baseline care plan. If the resident is identified as an elopement risk, the following will be maintained: Elopement Resident Identification form, including the current color photo, physical description of the resident, as well as approaches for an individualized plan of care will be in the elopement binder. Implementing and care planning interventions to address safety and decrease risk of elopement. The care plan will be updated to include that an electronic alarm system is used for resident's safety.II. Resident #1A. Resident statusResident #1, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), the diagnoses included traumatic brain injury (sudden injury to the brain caused by an external force, such as a blow, bump, or jolt to the head), psychotic disorder with delusions (presence of delusions, which are false beliefs that persist despite evidence to the contrary), alcohol dependence with alcohol induced dementia (abnormal memory), mental disorder due to unknown psychological disorder (conditions that affect a person's thoughts, feelings, and behaviors) and mood disorder due to unknown physiological condition (conditions that affect a person's emotional state).The 8/24/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He was independent with eating, toileting, dressing, personal hygiene, transfers and ambulating without any devices.The MDS assessment indicated the resident wandered.B. Resident #1's representative interviewResident #1's guardian was interviewed on 9/11/25 at 10:39 a.m. She said Resident #1 had a history of behaviors and eloping from other facilities after speaking with his mother. The guardian said the facility called her when Resident #1 eloped from the facility on 9/5/25. The guardian said that the resident enjoyed being outside. The guardian said the facility had outside space available for him to enjoy versus other locations he had been at prior. The guardian said when Resident #1 interacted with his mother, she felt this led to him wanting to leave and actually leaving the facility.C. ObservationsOn 9/10/25 at 10:15 a.m. the facility was observed to be a totally secure building specializing in serving residents with severe mental illness, dementia and behavioral health issues. The entire campus had a six-foot high security fence around the whole campus with a wired overhang in the unrestricted front resident space to discourage anyone from climbing over the fence. Staff and visitors had to be keyed in and out of the front gate. On 9/10/25 at 10:48 a.m. Resident #1 was in his room with a one-to-one staff member in the hallway. On 9/10/25 at 12:55 p.m. Resident #1 was sitting on a bench in the front patio with a staff member nearby with a clip board documenting the resident's location. On 9/11/25 at 8:02 a.m. Resident #1 was outside in the front courtyard in line of sight of a staff member.D. Record reviewThe elopement care plan, dated 8/19/25, revealed the resident was identified as an elopement risk. Pertinent interventions included placing the resident's identification information in the facilities development binder (initiated 8/19/25). The secure placement care plan, dated 8/19/25, documented Resident #1 required a secure unit placement related to impaired cognition, history of alcohol dependence, neurological conditions