STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to promote self-determination for three (#10, #4 and #13) of six residents reviewed for preferences and choices of 13 sample residents. Specifically, the facility failed to assess the resident daily preferences for care routine; identify interventions to meet the daily routine/care provision preferences of each resident; communicate the resident preference to staff through a plan of care and implement care based on resident self-determined preferences. Identified resident preferences included: -Ensure residents had the opportunity to explore options; daily life choices; and participate in the development of individualized person centered interventions for having a sense of control over daily life and self-determination while living in the facility; -Provide Resident #10 the opportunity to choose and participate in activities of interest; -Ensure Resident #10, #4 and #13 was able to determine their desired bathing schedule; and, -Ensure resident care plans document specific person centered information about a resident's individualized self-determined choice for daily routines and activity preferences, for Resident #10, #4 and #13. Findings include: I. Facility policy The Self-determination policy was provided by the nursing home administrator (NHA) on 3/2/23 at 3:38 p.m. It read in pertinent part: The patient/resident (hereinafter 'patient') has the right to, and the Center must promote and accommodate, patient self-determination through support of patient choice including, but not limited to the right to: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Choose activities, schedules (including sleeping/waking times, eating, bathing), health care, and providers of health care services consistent with their interests, assessments, and plan of care; -Make choices about aspects of their life in the (facility name) that are significant to the patient; -Interact with members of the community and participate in community activities both inside and outside the Center; -Participate in other activities including social, religious, and community activities that do not interfere with the rights of other patients in the Center. Purpose: To ensure each patient has the opportunity to exercise his/her autonomy regarding those things that are important in their life. The Treatment: Considerate and Respectful policy, revised 7/1/19, was provided by the NHA on 3/2/23 at 3:38 p.m. It read in pertinent part: (Facility name) will promote respectful and dignified care for patients in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life while recognizing each patient's individuality. -Dignity means that in their interactions with patients, any staff, including temporary or volunteers, carry out activities that assist the patient to maintain and enhance his/her self esteem and self-worth and incorporate the patient's needs, preferences, and choices. To provide patients the right to a quality of life that supports independent expression, decision making, and respect. Staff will show respect when communicating with, caring for, or talking about patients. Examples of promoting dignity include, but are not limited to, the following: -Grooming: Patients will be groomed as they wish to be groomed; -Activities: Assist patients to attend activities of their own choosing: II. Resident #10 A. Resident status Resident #10, age 82, was admitted on [DATE]. According to the March 2023 computerized physician's orders (CPO) diagnoses included legal blindness, anxiety disorder, major depressive disorder and lower back pain. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 1/20/23 minimum data set (MDS) assessment, the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15; no delirium or behavioral symptoms were documented. The resident was unable to walk and needed extensive assistance mobility, transfers, toileting and limited and guided assistance with dressing, personal grooming and bed mobility. The resident needed substantial/maximal assistance with showering where the helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort. Bathing however, did not occur during the assessment. The assessment documented it was very important to the resident to choose what clothes to wear; take care of personal belongings; to choose bed time; to have books, newspapers and magazines to read; and to do favorite activities. It was somewhat important to choose the way a bath was provided. B. Resident interview Resident #10 was interviewed on 3/2/23 at 11:00 a.m. Resident #10 said she had not had a shower since Thanksgiving 2022. On that day a certified nurse aide (CNA) assisted her to the shower room in a poorly fitting rolling shower chair. The chair caused her a great deal of pain due to its large size and poor fit. Resident #10 said facility staff told her another community within the corporation had a shorter small shower chair they would borrow but it never happened. The resident said she would really like a shower instead of the occasional bed bath staff provided. The shower chairs in the facility cause so much pain that the resident was unwilling to be put back into the chair until the facility gets a better fitting shower chair because she was worried about re-experiencing pain. Resident #10 said a shower would make her feel better and she would like to take a shower twice a week Resident #10 also said learning and education was very important to her, she wanted to find a way to take some college courses and earn a college degree. Resident #10 said she knew she would not be able to attend college in person, she did not have a computer or laptop and she had no idea what her options for continuing education were. Resident #10 said activities staff visited her regularly. Resident #10 said she enjoyed the visits, but activities staff had never taken her education goals seriously nor had anyone helped her explore her options. At the very least I would like to get an accessible computer to write my story but no one ever takes the time to ask what I crave or what would stimulate my mind.I still have my mind and I believe I have several more years of life left, I want to feel productive and accomplished in the time I have left. Resident #10 said she had books on tape and a roommate she enjoyed living with but that was not enough for her. Resident #10 said she would be interested in looking into some low cost or free online educational opportunities. C. Record review Resident #10's comprehensive care plan documented a care focus for daily routines. The care focus last revised 1/2/23, documented While in the facility, Resident #10 will engage in daily routines that are meaningfully relative to her preferences. She prefers to stay in her room by choice. Prefers her own leisure interests, television, family, and spirituality. She does have talking books. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #10 states she is not a crowd person so she is not interested in any groups. -Resident #10 has a good relationship with her roommate. She does enjoy the Daily Chronicle and verse of the day, activity staff reads it to her as she allows. -The care plan did not document resident specific preferences for learning or a desire to pursue higher education. -Additionally, the care plan did not document the resident's preferences for showering. III. Resident #4 A. Resident status Resident #4, age 77, was admitted on [DATE]. According to the March 2023 CPO, diagnoses included history of stroke, osteoarthritis, kidney failure and weakness. According to the 1/19/23 MDS assessment, the resident had intact cognitive ability with a BIMS score of 15 out of 15; no behavioral symptoms were documented. The resident was unable to walk and needed extensive assistance with bed mobility, toileting, dressing, personal grooming and transfers. Bathing/showering did not occur during the assessment period so the resident bathing needs were not assessed. Resident #4's preferences revealed it was important for the resident to choose the type of bathing received. B. Resident interview Resident #4 was interviewed on 3/1/23 at 2:42 p.m. Resident #4 said she had not had regular showering assistance since admission (1/13/23). Resident #4 said she really wanted to take showers three times a week. Resident #4 said she asked one of the CNAs to help her in the shower but no staff had been able to assist her to take a shower nor had any staff asked her about her showering preferences. C. Record review Resident #4's comprehensive care plan initiated 1/16/23 failed to document the resident's bathing needs or preferences. The residents' care task record documented the resident was scheduled to get showers twice a week Wednesday and Saturday evenings. The task record documented the resident had two showers in the last 30 days (2/12/23 and 2/27/23). IV. Resident #13 A. Resident status (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13, age of 94, was admitted on [DATE]. According to the March 2023 CPO diagnoses included legal blindness, hypertension, pain and chronic falling. According to the 2/8/23 MDS assessment, the resident had intact cognition with a BIMS score of 12 out of 15; no behavioral symptoms were documented. The resident had highly impaired vision - object identification in question, but eyes appear to follow objects. The resident was able to walk with an assistive device (walker) and was independent with activities of daily living (ADLs) once staff assisted the resident with set up. The resident needed substantial/maximal assistance with showering where the helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort. The resident's bathing needs were not assessed and bathing did not occur during the assessment. The assessment documented it was very important to the resident to choose what clothes to wear; take care of personal belongings; to choose bed time; to have books, newspapers and magazines to read; and to do favorite activities. It was somewhat important to choose the way a bath was provided. The resident preferences were not assessed. B. Resident interview Resident #13 was interviewed on 3/2/23 at 12:52 p.m. Resident #13 said she did not remember the last time she had a shower but it had been a while. I feel cleaner when I shower. Resident #13 said staff did not provide her regular showing assistance but she would have liked to shower twice a week; instead, she was giving herself a sponge bath. C. Record review Resident #13's comprehensive care plan revised 9/8/22; read in part: While in the facility, Resident #13 states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to her preferences. It is important for me to choose between a tub bath, shower, bed bath or sponge bath. The residents care task record documented the resident had two showers in the last 30 days (2/10/23 and 2/17/23). V. Staff Interviews CNA #1 was interviewed on 3/1/23 at 1:33 p.m. CNA #1 said resident showers were provided based on the care plan schedule as documented on the resident's task record. The documented schedule was to be followed. If the resident refused a shower time the CNA could ask the CNA on the next shift to offer the resident a shower during the next shift. The CNAs were to document the resident shower and response to the shower on the task record. The facility did not use any other method of documenting a resident shower being successfully given or refused. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #1 was interviewed on 3/1/23 at 3:02 p.m. RN #1 said as far as she was aware residents were being offered showers based on the shower schedule. Shower schedules were documented in the resident's care plan and ADL task record. If a resident refused a shower the CNA was expected to report the refusal to the nurse and the nurse was expected to encourage the resident to shower. If the resident continued to refuse showers, the nurse was to document the attempts and resident's response. The CNA was to document the resident's refusal in the resident's task record. The nurse was not aware of any concerns with either Resident #4 or #13 not receiving regular showering assistance. Licensed practical nurse (LPN) #1 was interviewed on 3/1/23 at 1:50 p.m. LPN #1 said shower schedules were documented in the ADL task record. If a resident reused a shower the CNA was expected to report the refusal to the nurse and the nurse was expected to make an attempt to convince the resident to shower. If the resident refused the offered shower, the nurse was to document the attempts and resident response. The CNA would document the refusal in the resident's record and on the shift report and staff could give the resident a shower opportunity the next shift or the next day. LPN #1 had no concerns that residents were not being offered regular showering assistance. LPN #2 was interviewed on 3/1/23 at 5:02 p.m. LPN #2 said residents sometimes missed showers when the CNAs were short staffed. However, when staff were unable to assist a resident with showers staff were expected to provide the resident an alternative shower time to make up for the missed showers. All showering assistance was to be documented in the resident's record whether they accepted or refused showering assistance. Due to staff availability and resident needs, it was possible for a resident to miss a scheduled shower not due to the resident's refusal. The NHA and unit nursing manager (UNM) were interviewed on 3/2/23 at 2:00 p.m. The NHA said Resident #10 had a history of refusing showers but acknowledged she was unaware of why the resident had been refusing showers. The NHA was not aware the resident wanted showers but refused because she was fearful of being in pain from sitting in the shower chair. The NHA said the facility had several shower chair options that might work for the resident. The NHA said Resident #10 received in room visits from the activities department. The NHA was unaware of the resident desire to pursue educational opportunities. The NHA said she would ask activities to talk to the resident about her preferences. The NHA said the CNAs were expected to offer residents showering assistance based on the resident's showering schedule; if the resident refused then were to reproach later in the day. If the resident continued to refuse, the CNA was to report to the floor nurse and the nurses were to attempt to offer the resident a shower. The nurse was to document attempts to offer the resident showering assistance and the CNA was to document the resident response on offers to receive a shower. The NHA said she was not sure why Resident #13 was not getting showers but though it was likely, the resident was refusing showers when offered. The NHA and UNM reviewed Resident #13 ADL task record and acknowledged there was no documentation of the resident refusing showers. The NHA said Resident #4 had moments of confusion and thought she might be confused about not getting regular showering assistance. The NHA and UNM reviewed the resident task record and acknowledged there was no documentation of Resident #4 refusing showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 3/2/23 at 4:00 p.m. The NHA said there was a glitch in the task record system for some residents where the CNAs were not able to document the resident response to showing assistance and if the shower was given or not. The UNM was currently reviewing the resident records and fixing the entry glitch so staff could accurately document the resident's response to showering assistance.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure notification of change for one resident (#2) of three residents reviewed out of 13 sample residents. Specifically, the facility failed to make a timely notify Resident #2's legal representative of a medication change, timely. Findings include: I. Resident status Resident #2, age under [AGE] years old, was admitted on [DATE]. According to March 2023 computerized physician orders (CPO), diagnoses included paranoid schizophrenia, drug induced subacute dyskinesia (involuntary movements), ischemic attack (stroke), and cognitive communication deficits. The 1/23/23 minimum data set (MDS) assessment revealed Resident #2 did not complete the brief interview for mental status (BIMS); staff instead assessed the resident's cognition. The assessment revealed staff assessed the resident to have short-term memory impairment but had no impairment with long-term memory. The resident was able to recall the seasons; location of the room and names and faces of the staff. The resident had impaired skill for daily decision making and had some difficulty in new situations. The resident had no symptoms of delirium or disorganized thinking. The resident was taking daily antipsychotic and antidepressant medications on a routine basis. II. Record review Review of the resident record and interviews revealed the resident's legal representative was not notified by facility nursing staff or by the resident prescribing physician of changes in the resident psychotropic medication or results of diagnostic testing regarding unresolved leg pain. Care plan meeting note dated 12/27/22 at 12:05 p.m. read in pertinent part: (Resident #2 was having leg pain) Nursing will request an x-ray to see if there is anything else going on with the resident's foot that may keep him from reaching rehab potential. Referring to the resident to get an x-ray to see what is going on with leg and help him get back to baseline so that he can (gain full) rehabilitation. Nursing note dated 1/6/23 at 8:57 a.m., read: Per (resident's medical power of attorney), resident was supposed to have an x-ray done on both feet and ankle following the care plan meeting back on 12/27/22. Spoke with (the resident's physician) and received routine diagnostic orders for the x-ray to be completed. The x-ray was completed on 1/6/23 with no significant findings. Neither the progress notes or physician notes document next steps or discussion with the resident or medical power of attorney (MDPOA) on next steps and goals for pain relief. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practitioner visit note dated 2/24/23, read in pertinent part: This resident was seen and evaluated yesterday. Resident was in good spirits, without evidence of psychosis, and without any known incidents. (The resident) continues having a noticeable tremor, and obvious drooling, almost certainly a result of treatment with Haldol (antipsychotic medication). (The resident) was informed that these symptoms were from Haldol, and that he is taking an excessive amount of this drug. When initially seen, he was resistant to changing any of his medication; this may have been partly due to his (legal representatives input). (The resident) asked me to inform (the legal representative) of any med (medication) changes. (Resident) was told that facility nursing staff would advise (the legal representative) of any medication changes. It was emphasized to (the resident) that any medication changes made, are to help him functionally, as it is unnecessary to take the amount of medications that he is taking. (The resident) stated that he would like Haldol 5 mg (milligrams) daily be stopped, so the medication was discontinued as this writer also agrees that this is the best place to start. (The resident) was also informed about Ipratropium Bromide 0.06% nasal spray, which can be used as a spray below the tongue for his sialorrhea (hyper salivation or excessive drooling). (The resident) agreed to a trial of this med which was ordered at a starting dosage of 1 spray under the tongue. -The resident's progress notes failed to document notification to the resident's legal representative. III. Resident representative interview The resident's legal representative/medical durable power of attorney (MDPOA) was interviewed on 3/2/23 at 2:01 p.m. The MDPOA expressed several concerns about the resident care including lack of communication about medical treatment and care. The MDPOA said neither nursing staff nor the facility social worker made any attempt to communicate the resident's recent medication change regarding discontinuing the resident's Haldol. The MDPOA said the resident was the one who had made the notification that the practitioner had made change in the medication regime but was not able to specify when the change occurred or why the change occurred. The MDPOA would have liked to have been informed so there could have been a discussion about the reasons for the medication change and the goals of psychotropic medication changes. The MDPOA said it had been difficult getting notification and return calls about Resident #2's care. The MDPOA had to go in person to discuss the resident care and some of the nurses were not able to answer questions fully without having to wait for the nurse to call the provider and get back with answers. The MDPOA would like more regular communication from the facility about treatment decisions in order to be an active partner in developing an appropriate care plan for the resident. The MDPOA also said the resident was supposed to be assessed for pain in the lower extremities but was not sure of the outcome of diagnostic treatment or next steps in treatment. The resident was still experiencing pain and still had no relief. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/2/23 at 1:50 p.m. LPN #1 acknowledged being Resident #2's regular daytime nurse. LPN #1 said there had not been any occasion to call the resident's legal representative, so the LPN had never talked with the resident's legal representative. The LPN acknowledged the resident had recently been taken off Haldol due to developing drug induced Parkinson's-like symptoms and said the resident was doing much better. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and unit nurse manager were interviewed on 3/2/23 at 3:33 p.m. The NHA was not aware the Resident #2's legal representative was requesting regular communication from the facility regarding the resident's care and treatment. The NHA said the facility recently had a care conference on 12/27/22 to discuss resident care but she did not remember if medications were discussed at that meeting. The NHA had some recollection of a discussion around the resident's leg pain but did not recall the outcome of medical assessments. The NHA said she would contact the resident legal representative and offer to set up routine calls, in person meetings, or provision of a weekly written status report at a frequency beneficial to facilitate communication with the resident's MDPOA.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations and interviews the facility failed to provide a clean, safe, homelike environment for the residents, on the east side of the building in six of eight resident units/halls and in resident common areas. Specifically the facility failed to: -Ensure the environment resident halls and common area spaces were free of offensive bathroom odors and other body odors; -Ensure the handrails in resident halls were securely fastened to the walls; -Ensure resident rooms and hallways were clean and free from debris left on the floors; -Ensure the walls in resident rooms and halls looked home like; and were maintained in good condition; -Ensure cables and power cords were not loosely hanging from the wall or laying in walkways; -Ensure the rubber wall molding in resident rooms was securely attached to the wall and not hanging off the wall into walkways; -Ensure resident space was accessible to store and display personal items; and, -Consistently provide clean linens to the residents. Findings include: I. Facility policy The Accommodation of Needs policy, revised 2/1/23, was provided by the nursing home administrator (NHA) on 2/3/23 at 6:15 p.m. It read in part: The resident/patient (hereinafter 'patient') has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely. The (facility's name) physical environment and staff behaviors should be directed toward assisting the patient in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent possible in accordance with the patient's own needs and preferences. The (facility's name) must provide: -A safe, clean, comfortable, and homelike environment, allowing the patient to use his/her personal belongings to the extent possible. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-This includes ensuring that the patient can receive care and services safely and that the physical layout of the Center maximizes patient independence and does not pose a safety risk. -Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. -Clean bed and bath linens that are in good condition. -Private closet space in each patient room. II. Resident interviews Resident #4 was interviewed on 3/1/23 at 2:42 p.m. Resident #4 said she had talked to the maintenance director (MTD) several times about environmental concerns of a safety and accommodation of space nature, but the requests had not yet been addressed and it had been over a month since she made the requests. Resident #8 was interviewed on 3/2/23 at 10:55 a.m. Resident #8 said lingering foul odors throughout the halls were problematic. Smells traveled into her room from the hall. Resident #8 wanted to get an electronic odor diffuser but was unable due to a potential fire hazard so the resident opted for a tabletop air freshener. The resident pointed to her dresser where there was an air freshener that was mostly dry. Resident #8 said the air freshener was not effective to eliminate odors unless it was newly opened and right next to her bed. Resident #8 did not have any towels in the room and said she only got fresh towels if she asked for them. Resident #6 was interviewed on 3/2/23 at 11:33 a.m. Resident #6 said the facility environment needed a lot of improvement. She and several other residents complained about maintenance and housekeeping jobs not being compiled timely or effectively. Resident #6 kept a log of concerns to address with the resident council. Most of the time maintenance blamed delays on being short staffed; however, there were times when the maintenance department was not short staffed and they still did not complete repairs and upkeep in a timely manner. Resident #6 pointed to the wall in her room. The resident said the paint on that wall had been gouged with exposed plaster since moving into the room more than a year ago. Resident #6 said many other resident rooms and hallway walls were in the same disrepair. Resident #6 said housekeeping was much the same way resident rooms were not cleaned daily; she was luckier than most that she could tidy up her own room in housekeeping absence. Resident #7 was interviewed on 3/2/23 at 4:20 p.m. Resident #7 said there were strong smells on her unit that lingered and bothered her. Resident #7 said she had to open her window or spray room spray in order to get fresh smelling air. III. Observations On 3/1/23 at 1:46 p.m., resident room [ROOM NUMBER] has a slight smell of sweat and body odor; the bedside table has dried spilled chocolate milk over the surface, the trash can was overflowing with trash and empty chocolate milk containers. (continued on next page)

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	065147	A. Building B. Wing	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 1:55 p.m., resident room [ROOM NUMBER] was observed; the bedside table still had dried chocolate milk on it in addition to a spilled clear brown liquid and there was an open soda bottle on the tabletop. -Between 2:20 pm and 3:45 p.m., units 1100, 1200, 1300, 1400, 1500, and 1600 were observed: The hallways on units 1200 and 1300 were littered with small scraps of paper on the floor and empty alcohol swab packets. Observations on hallways 1100, 1200. 1300, 1400, 1500, and 1600 revealed: -The walls were soiled underneath the grab bars with several drips of dried liquid of a light tannish in color; the liquid was translucent and was dripping down the wall in several areas up and down the hall. The same walls were streaked with black marks and scrapes; -The majority of the residents' doors on each of the resident halls were scrapped at knee level and below down several layers of wood. There were several door jams and hall entry edges were the plaster was broken off; -Several walls had gouges exposing bare plaster. Some of the gouged areas were plastered but not painted; -In hallway 1300, there was a grab bar off the wall on the left side; the area had three large plastered areas. The plaster was dry and hardened, but left unpainted; -The shower room door to the hallway in hall 1300 and resident room [ROOM NUMBER] had old white/soiled half-inch tape still stuck on the door; the tape was frayed with black stains; -The 1400 hall had a slight odor; the odor resembled body odor sweat that was permeating from resident rooms; -In 1600 hall, not far into the hall, on the left side there was a grab bar hanging down and off the wall connected only by one side. The grab bar was wobbly and pull further away from the wall when grabbed; and, -None of the resident rooms had fresh towels for resident use. Observations of individual resident rooms revealed: -Several resident rooms on each unit had chipped paint from the walls by the residents' beds; -The areas around the sinks had chipped and peeling paint exposing plaster; and, -Several rooms had loose cable cords laying on the floor inches from the wall and laying in walkways. Observation of resident room [ROOM NUMBER] revealed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Approximately, two feet of rubber molding, in the walkway to bathroom, was peeling away from the wall in and hanging into the walkway; -The window had a long crack that had spread from one end to the other; -The bathroom had several areas of chipped paint under and around the sink and by the toilet; -There was no shower head sprayer on the shower spicket; -The walls under the heater on both sides of the room had plaster repaired walls that were not painted; -The residents' did not have any linens; -The resident had no place to store toiletries in the bathroom and had to keep toothbrushes on the windowsill that was next to the toilet, with in use toilet paper. There were shelves in the bathroom but they were placed high on the wall above the toilet where the resident in a wheelchair could not safely reach; and, -The closet space was not accessible to the resident because it was blocked by an unused television set. Other resident room observations: -room [ROOM NUMBER], the wall beside the bed closest to the door, at the location where the resident's upper body would lie had dried brown matter; and, -room [ROOM NUMBER], the wall next to the window at knee level had dried brown matter on it. On 3/2/23 at 9:45 a.m., units 1600 and 1300 had a strong lingering body and sweat odor. hall 1300 also had a strong urine odor. -At 4:00 p.m. unit 1300 and a strong odor of body and urine odor. The common area around the East side lobby connecting to the resident units had a strong linger odor of feces. III. Record review Facility work request records for September 2022 to February 2023 were reviewed, records revealed there were needed repairs for plumbing, heating air conditioner units, lighting, resident equipment, along with odd job requests from residents', in addition to: On 11/23/22, staff reported a broken handrail on the 1100 hall. The repair was listed a medium priority. Maintenance documented on entry that the repair was made on 12/11/22. IV. Staff interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #1 was interviewed on 3/1/23 at 4:55 p.m. LPN #1 said the large plastered area in hall 1300 had been left up painted for a couple of weeks. LPN #1 was not sure how long the handrail in hallway 1600 had been broken and hanging off the wall. LPN #2 was interviewed on 3/1/23 at 5:02 p.m. LPN #2 said several handrails were broken throughout the facility going back to September 2022. It took several months for maintenance to remove and fix the handrails. LPN #2 said the handrail on hallway 1600 had been hanging off the wall for quite a while. The MTD was interviewed on 3/1/23 at 6:00 p.m. The MTD said the building needed a lot of repairs and he had a plan to complete the needed repairs over the next 12 months starting with safety issues first. The MTD said the system for repairs was for staff to put in a computerized repair request and then place the request on a clipboard list of need where repairs involving safety hazards got first priority. The MTD acknowledged delays in completing facility repairs was due to being understaffed. The MTD said the maintenance department was fully staffed and the first safety repair priority over the next 30 days was to secure loose cable and electrical cords in resident rooms. The MTD acknowledged there were a lot of loose and hanging cords in the resident room that needed securing, due to a potential of being a safety hazard. The MTD attributed the cause of this problem to frequent resident rooms moves and residents families desire to rearrange furniture which often left electric and cable cords in unsafe places. What made it harder to keep up was that the nursing staff did not always notify the maintenance department of repair needs and they did not have the capacity to make daily checks in each resident's rooms for areas needing repairs. The MTD said he would address the hanging handrail on 1600 immediately to get it secured to the wall; and fix the hanging cable cord and baseboard in Resident #4's room. Then NHA and unit nursing manager (UNM) were interviewed on 3/2/23 at 2:00 p.m. The NHA said the maintenance department had struggled to hire staff up until recently. The NHA said there was a priority list for repairs. The housekeeping supervisor (HSKS) was interviewed on 3/2/23 at 4:19 p.m. The HSKS said resident rooms were supposed to be cleaned daily; however, that did not always occur due to staffing shortages. The HSKS was working on retraining the housekeepers (HSKP) to make sure to move furniture and resident beds so they could thoroughly clean the entire floor in each room. The HSKP where to use peroxide while cleaning plus use an enzyme clean chemical to cut odors particularly in the bathrooms where odors linger from spills and accidents involving bodily fluids. The HSPS acknowledged the walls in the hallways were soiled and needed to be cleaned. The HSKS said she started to clean the walls in the common area this morning and would make the hall a special project. Other special projects involved floor clearing; the facility hired a floor technician and the staff's training started. The HSKS said in addition to the daily cleaning tasks, deep cleaning for the resident hallways was once a week and once a month for resident rooms. The HSKS said she looked at the wall next to the resident's bed in room [ROOM NUMBER]; it appeared the resident was spitting on the wall and no staff cleaned it. The wall was [NAME] and HSKP staff were alerted to monitor and clean the wall when cleaning the rest of the room.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to prevent an accident involving hot liquid which caused a second degree burn with one (#1) of three out of 13 sample residents. On 1/21/23 at 2:45 p.m. Resident #1 was found to have a large blistered and reddened area on the right thigh. Nursing staff were unable to explain how the injury occurred. A physical assessment and investigation was initiated. Nursing staff revealed the resident was assessed to have two burn sites on the right thigh. The resident was experiencing pain at the burn site (see more information below). On 1/24/23, the resident was examined for an initial evaluation with a wound care physician. The physician diagnosed the resident with a second-degree burn to the upper right thigh. The physician measured the burn site. The total wound surface burn site with blistering, measured 3.0 centimeters (cm) by 9.3 by 0.1 cm (length by width by depth). There were two other burn site area one reddened and blistered and the other reddened and non-blistered the proximal (closer to the torso) area of redness measured 1.0 cm by 3.0 cm by 0.0 cm; the distal (furthest from the torso) area measured 2.5 cm by 2.8 cm by 0.0 cm. According to the investigative summary dated 1/29/23, documented that during incontinent care performed on 1/21/23 at approximately 2:45 p.m., Resident #1 was found with redness and blisters on the upper right thigh; staff providing care had no indication what had caused the injury. After further interviews with staff over the next couple of days, it was determined the injury was a burn caused by an unknown substance. The facility failed to provide appropriate supervision and ensure a safe environment for Resident #1 to prevent the resident from sustaining a second-degree burn with redness and blistering, to the thigh. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 3/1/23 to 3/2/23, resulting in the deficiency being cited as past noncompliance with a correction date of 1/27/23. I. Facility policy The Food Handling policy, revised on 6/15/18, was received from the nursing home administrator (NHA) on 3/1/23 at 1:24 p.m. It read in pertinent part: Hot beverages are to be served at a pleasing temperature, to the residents, but in a manner that reduces the risk for burns. Follow recommendations for reheating beverages in the microwave found in (Guidelines for Hot Beverages). Hot beverages such as coffee, tea and hot chocolate are held at high temperatures (160-185) degrees Fahrenheit (F). Brief exposures to liquids at these temperatures can cause significant scald burns. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When serving hot liquids to residents, consider the following: -Dispense the beverage in a plastic mug; not a styrofoam cup. -Do not overfill the drinking cups. -Place the beverage away from the edge of the table and near the patient's dominant hand. -Explain to the patient that a hot liquid is being served. -Place the beverage in the patient's field of vision. -Transfer the hot beverage from the coffee urn to a serving container. II. Resident #1 A. Resident status Resident #1, under the age of 65, was admitted on [DATE]. According to the March 2023 computerized physician orders (CPO) the diagnosis included burns of unspecified degree to the right thigh, underweight, anemia, dementia, and major depressive disorder. The 2/6/23 minimum data set (MDS) revealed the resident was not able to be assessed with the brief interview for mental status (BIMS) due to short-term and long-term memory impairments. The resident had disorganized thinking and was not able to focus attention on conversations nor was the resident able to make herself understood or understand most conversations. The resident required extensive assistance with bed mobility, transfers, dressing, toilet use, hygiene, bathing, and moving back and forth on the unit. The resident was independent with eating once set up. B. Record review Burn incident investigation On 1/21/23 an internal investigation report documented Resident #1 received a second degree burn to the right upper thigh over 0.5 percent of the body. The initial proximal blistered wound measured 1.7 cm by 2.1 cm by 0.0 cm; the distal blistered wound measured 3.0 cm by 9.3 by 0.1 cm; the proximal non -listered reddened wound measures 1.0 cm by 3.0 cm by 0.0 cm; the distal non-blistered reddened wound measured 2.5 cm by 2.8 cm by 0.0 cm. The actual cause of the burn was undetermined. The burn injury was discovered on 1/21/23 at approximately 2:45 p.m., shortly after change of shift with incontinent care during first rounds. The certified nurse aide (CNA) working the prior shift denied any knowledge of how the resident could have sustained the second degree burn and denied observing any redness when the resident was last changed on the day shift (reportedly 11:00 a.m.). Initial wound care treatment included a cold compress followed by application of a non-stick bandage pending physician assessment and treatment recommendations. The investigation documented the facility was unable to determine the exact time the resident's burn was sustained. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident note dated 1/21/23 at 7:20 p.m., documented the resident was assessed after staff observed reddened and blistering areas on the top of the resident's right thigh. During nursing assessment, the resident experienced moderate pain as evidenced by a score of 5 out of 10 (with 10 being the worst pain on the scale) on the pain assessment in advanced dementia (PAINAD) scale. Symptoms of pain included occasional moan or groan; low level of speech with a negative quality; facial grimacing; and, tense distressed pacing. Nursing note dated 1/21/23 at 7:29 p.m, documented: A change in condition reported: Evaluation are/were: Change in skin color or condition. Nursing observations, evaluation, and recommendations are: Attending nurse requested assistance with assessment of residents leg. Leg appeared reddened in areas, rounded. Several of the red areas had what appeared to be blisters. On call provider was notified; treatment orders were given. Physicians orders read Silvadene (silver sulfadiazine) external cream 1 percent. Apply to the right anterior thigh topically, two times a day for wound care. Gently cleanse the area with wound cleanser- apply silvadene-cover with a sterile bandage and kerlix. Order date 1/21/23. Physician's visit note read in part: Date of encounter: 1/24/23. Medical necessity of visit: follow up on burns. Chief complaint: Resident #1 has two different areas to her right upper leg, the distal area is second degree burn, no open or fluid filled blistering noted, the proximal burn area is a second degree burn, there was a fluid filled blister but this has opened. Staff report that they believe she poured hot coffee on her leg which caused the burn. Wound care physicians note dated 1/24/23 documented the resident was examined for initial assessment and treated for second degree burns to the upper right thigh, four days after the injury was sustained. The resident wounds were cleansed and an antimicrobial dressing was applied with a dry outer dressing. The resident experienced pain during care responding with occasional negative vocalizations, a sad frightened frown, tense body language but was consoled. The comprehensive care plan revised 1/24/23, documented Resident #1 was at risk for burns from hot beverages due to no safety awareness as evidenced by a history of wandering and grabbing cups and objects from tables and counters. The gaol was resident will have no further injuries from hot beverage spills onto lap. Interventions included: -Increase visual checks for safety during meals to aid in preventing Resident #1 from grabbing other items from the table that do not belong to her; -Seating arrangements to allow Resident #1 to sit with other residents that do not drink hot beverages; and, -Provide resident/patient with set-up and supervision with cues to extensive assist for eating. C. Observations (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/1/23 at 5:24 p.m., Resident #1 was observed self propelling throughout the unit in a manual wheelchair reaching out to grab at staff and residents as they walked passed by. A CNA on the unit approached and assisted the resident to the dining room. The resident was seated away from others with hot liquids in front of a table tray and served the dinner meal. Resident #1 at the meal remaining in place until the meal was done. When the resident was finished eating, the CNA removed the table tray and the resident continued roaming around the unit touching every person who she passed. III. Staff interviews The dietary manager (DM) was interviewed on 3/1/23 at 1:30 p.m. The DM said the coffee was brewed in one machine in the kitchen and then transferred to a stainless steel thermos dispenser to be served to the residents. The coffee was tempted prior to being taken to the dining room and resident floors for service. The DM said the temperature of the coffee should be 160 degrees F or lower. If steam was coming off the poured coffee it was most likely too hot to serve. Staff were educated to monitor the coffee dispenser and inspect any resident attempting to operate the dispenser on their own. The DM said hot liquid at above 160 degrees had the potential to cause scalding burns. CNA #2 was interviewed on 3/2/23 at 10:20 a.m. CNA #2 said she was working from 6:00 a.m. to 2:00 p.m., on 1/21/23, the day this resident was burned. CNA #2 she had not observed the resident spilling any ot liquids and had not observed any signs that there was any hot liquid spilled around the resident; and Resident #1 never complained of pain throughout the day shift. CNA #2 said she provided incontinent care for Resident #1 just before lunch, at approximately 11:00 a.m. The resident's pants were wet around the brief but not on the resident's legs. Unit nurse manager (UNM) was interviewed on 3/2/23 at 11:10 a.m. The UNM said Resident #1 needed to be monitored because she was reaching to grab items from other residents' tables and the drink carts which caused a safety concern. The UNM said no staff knew what time the resident burn occurred on 1/21/23 or how the burn occurred, but it might be possible that the resident spilled some hot liquid on herself. The NHA was interviewed on 3/2/23 at 12:00 p.m. The NHA said Resident #1 had sustained a second degree burn to the right thigh, requiring the resident to start seeing the wound care physician to treat the burn. The wound was healing but still required ongoing wound care treatment and monitoring by nursing staff and the wound physician. Immediately following the discovery of the resident burn, the facility investigated for possible causes and preventative measures. The resident care plan was updated with new safety interventions and all staff were educated to follow the revised care plan to maintain the resident's safety. Licensed practical nurse (LPN) #4 was interviewed on 3/2/23 at 1:00 p.m. LPN #4 said Resident #1 was impulsive and was touching things all the time. LPN #4 said the resident was non-verbal so staff were unable to find out exactly how the resident was injured. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #3 was interviewed on 3/2/23 at 3:30 p.m. CNA #3 said she worked on 1/21/23, during the evening shift from 2:00 p.m. to 11:00 p.m. CNA #3 said she came on shift and started rounding and checking on resident needs. Resident #1's briefs were soiled upon checking in on the resident. CNA #3 provided Resident #1 incontinence care at approximately 2:45 p.m. and noticed redness and blisters on the resident's right thigh. CNA #3 reported the resident's injury to the nurse for further assessment. Because no staff on duty know how the injury occurred, CNA #3 called CNA #2, as that CNA had worked with the resident on the prior shift. CNA #3 said CNA #2 denied knowledge of Resident #1 injury and said the resident did not have any signs or symptoms of an injury or burn during the day shift. IV. Facility corrections Interview and record review during the complaint investigation revealed the facility investigated this singular event and implemented corrective actions to prevent reoccurance. The care plan was revised with interventions for staff to set Resident #1 up to be separated from other residents who drank hot liquids. Since Resident #1 did not consume hot liquids. The resident was not in jeopardy of being burned by her own drinks but was at risk from grabbing hot liquids from peers consuming such beverages. The care plan interventions included placing Resident #1 away from hot liquids at meals and monitoring the resident during the meal. Observations and interviews during the survey revealed staff were consistently following the care plan interventions and the resident had not experienced any further problems being injured by hot liquids. The facility determined all residents in the facility were at risk for being burned by hot coffee or any other hot beverage such as tea or hot chocolate, if not properly brought to a safe temperature for serving. The dietary department educated dining aides to make sure hot liquids did not exceed 160 degrees F when serving to a resident. Coffee for example was to be tempted properly, in the kitchen at each service, to make sure its temperature met the recommended 160 degrees F prior to taking it to the dining room or to the resident units for service to the residents. Additionally, staff were instructed that residents were not permitted to dispense coffee directly from the stainless dispensers. Signs were posted on the coffee and hot water dispensing containers warning residents to ask for assistance due to the risk of being burned. All nursing staff were educated to follow Resident #1's revised care plan intervention to prevent reoccurance of the resident being burned as of 1/27/23. Interviews with the NHA confirmed the corrective actions, and therefore the facility's substantial compliance, by 1/27/23, at the time of the survey conducted between 3/1//23 to 3/2/23. 42193