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	12/11/2025

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 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. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a comfortable and homelike environment for residents on three of four units.Specifically, the facility failed to:-Ensure residents were provided clean washcloths;-Ensure broken towel racks and window seals in residents room were fixed timely,-Ensure residents' rooms were clean; and,-Ensure the lights in the residents' shower room were fixed timely. Findings include:I. Facility policy and procedureThe Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:11 p.m. It read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment.II. Environmental tour and interviewEnvironmental tours were completed on 12/10/25 at 2:20 p.m. and on 12/11/25 at 5:05 p.m. The following was observed: Resident rooms #300, #301, #304, #400, #401, #404, #410, #500, #503, #506, #507, #702, #703, #704, #705, #706, #1103, #1104, #1106, #1108, #1208, #1307, #1404, #1406, #1410, #1503, #1506, #1510, #1603, #1605 and #1607 had broken towel racks and there were no towels in the resident rooms.Rooms #1308, #1407, and #1408 had two resident occupants and only one towel rack. The resident in room [ROOM NUMBER]B had a broken window seal. There was a trash bag left on the floor outside the bathroom. Resident room [ROOM NUMBER] was dirty, with the tile floor appearing hazy and muted. The light fixture in the main shower room of the [NAME] unit had broken loose from the mounting and was dangling from the ceiling. A jagged ring of cracked drywall surrounded the gaping hole where the fixture once sat, leaving the internal electrical box exposed. The glass cover hung suspended y by a pair of twisted, color-coded wires.III. Resident interview The resident in room [ROOM NUMBER]B said the broken window seal enabled ants to enter the room when it rained. She said they used paper towels and they only received wash towels when they asked for it. The resident said they have not had a towel rack for a while.IV. Staff interviewCertified nurse aide (CNA) #3 was interviewed on 12/10/25 at 2:14 p.m. CNA #3 said all nursing staff were responsible for ensuring the residents' rooms were clean and were stocked with towels each day. He said wash towels were provided to the residents who asked for them.The maintenance director (MTD) was interviewed on 12/11/25 at 5:00 p.m. The MTD said he was not aware most of the residents' rooms had broken and missing towel racks. He said he completed a facility-wide room audit of all towel racks and had placed an order for 45 towel racks. The MTD said she will begin installation of all the broken racks as soon as the order arrives at the facility. The MTD said nursing staff were to initiate work orders through the facility's electronic work order system for the replacement of towel racks when they were broken. He said the window seal in room [ROOM NUMBER] would be immediately fixed. The MTD said the maintenance department completed monthly audits of all equipment, and he could not tell the reason the towel racks were missed.The assistant director of nursing (ADON) was interviewed on 12/11/25 at 6:35 p.m. The ADON said the CNA's, together with all nursing staff, were responsible for providing towels for all residents. She said every resident's room should have a towel rack for the resident's towel.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect two (#111 and #66) of eight residents from abuse out of 53 sample residents.Specifically, the facility failed to protect Resident #111 and Resident #66 from physical abuse from each other. Findings include:I. Facility policy and procedureThe Abuse, Neglect, and Exploitation policy, undated, was provided by the nursing home administrator (NHA) on 12/10/25 at approximately 4:00 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, intimidation, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.II. Incident of physical abuse between Resident #111 and Resident #66 on 10/18/25A. Facility investigationThe facility abuse investigation was provided by the NHA on 12/10/25 at approximately 4:00 p.m.The facility investigation documented on 10/18/25 at 6:15 p.m. certified nurse aide (CNA) #9 witnessed Resident #111 and Resident #66 facing each other and making hand-to-hand, swatting gestures at each other's hands and arms and making contact. The investigation documented CNA #9 immediately intervened by separating the residents and redirecting each resident in separate directions. CNA #9 notified the nurse on duty of the interaction. No injuries were reported at the time of the incident. -However, record review revealed Resident #111 sustained a skin tear to the back of her left hand (see record review below).The investigation documented both residents were interviewed after the incident. Both residents were unable to answer questions when interviewed. The investigation documented staff were reminded of the importance of monitoring resident interactions in common areas. B. Resident #1111. Resident statusResident #111, age [AGE], was admitted on [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included severe unspecified dementia with other behavioral disturbances (cognitive decline with behavioral issues like agitation, wandering, depression) and cognitive communication deficit (difficulty talking or understanding due to impaired thinking skills).The 10/22/25 minimum data set (MDS) assessment identified Resident #111 was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. The resident walked independently and required set up assistance with eating and substantial/maximal assistance with showering and dressing.C. Record reviewResident #111's psychosocial/behavioral care plan, revised 10/20/25, revealed Resident #111 exhibited behaviors of striking out, grabbing others and verbal aggression toward others. Pertinent interventions included to encourage and supply the resident with activities of her interest and offering to remove her from areas of high traffic and stimulation. The care plan directed staff to observe Resident #111 and ensure the resident stayed away from residents she had known altercations with.The 10/18/25 nursing progress note at 6:15 p.m. documented at 6:15 p.m. Resident #111 and Resident #66 were both being physically aggressive towards each other. No injuries were noted at the time. The two residents were separated. Resident #111 was assessed and found to have a skin tear on the back of her left hand. The residents were placed on 72-hour charting checks following the altercation with no further physical aggression noted.C. Resident #661. Resident statusResident #66, age [AGE], was admitted on [DATE]. According to the December 2025 CPO, diagnoses included vascular dementia (a decline in thinking skills from reduced blood flow to the brain often from strokes or chronic high blood pressure) and muscle weakness.The 9/9/25 MDS assessment identified Resident #66 was severely cognitively impaired with a BIMS score of seven out of 15 and used a wheelchair. The MDS assessment identified Resident #66 had vocal symptoms such as screaming and making disruptive sounds.2. Record reviewResident #66's psychosocial/behavioral care plan, revised 10/20/25, revealed Resident #66 exhibited behaviors of physical aggression with other residents. Pertinent interventions included encouraging and supplying the resident with activities of her interest and to offer to remove her from areas of high traffic and stimulation, observing Resident #66 and ensuring the resident stayed away from residents she had known altercations with.D. ObservationsOn 12/10/25 at 4:00 p.m. Resident #111 was yelling Get your (explicit language) out of here in the main common area where multiple residents were located. Resident #111 had furrowed eyebrows, pressed lips, and her stare was fixed in the direction of the residents in front of her. She was leaning forward with her walker and her head and neck were also extended forward. Her elbows were slightly outward and

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.Specifically, the facility failed to:-Ensure housekeeping staff followed proper cleaning procedures for cleaning and disinfecting resident rooms and high-frequency touched areas; and ,-Ensure housekeeping staff performed hand hygiene and glove changes appropriately. Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 12/18/25 fromhttps://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.htmlHigh-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.Common high-touch surfaces include: bedrails; IV (intravenous) poles; sink handles; bedside tables; counters; edges of privacy curtains; patient monitoring equipment (keyboards, control panels); call bells; and, door knobs.According to the CDC's Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 12/18/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, To protect themselves and their patients from deadly germs, all healthcare personnel should understand proper hand care and cleaning techniques. Hand hygiene, which protects both staff and patients, involves cleaning hands by washing with soap and water, using antiseptic hand rubs (such as alcohol-based foams or gels), or performing surgical hand antisepsis. Cleaning your hands reduces the potential spread of deadly germs, including those resistant to antibiotics, to patients. It also lowers the risk of healthcare personnel becoming colonized or infected by germs acquired from patients. Because some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep everyone safe, maintaining healthy skin is a common challenge.According to the CDC Hand Sanitizer Guidelines and Recommendations (3/12/24), retrieved on 12/18/25 from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html,Germs are everywhere. They can get onto hands and items we touch during daily activities and make us sick. Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you.There are important differences between washing hands with soap and water and using hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount). Cover all surfaces of hands. Rub your hands and fingers together until they are dry. This should take around 20 seconds. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.II. Facility policy and procedureThe Cleaning and Disinfecting Resident Rooms policy, revised September 2022, was provided by the nursing home administrator (NHA) on 12/11/25 at 4:11 p.m. It read in pertinent part, Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC disinfection recommendations and the OSHA Bloodborne Pathogens Standard.Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (urinary catheters) or the vascular system (intravenous catheters) are considered critical items and must be sterile when used, based on acceptable sterilization procedures. Sterilization destroys all viable microorganisms to prevent disease transmission associated with the use of that item.The Hand Hygiene policy, revised October 2023, was provided by the NHA on 12/11/25 at 3:51 p.m. It read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors.III. ObservationsDuring a continuous observation on 12/11/25, beginning at 9:03 a.m. and ending at 9:43 a.m., housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER] on the Columbine unit.HK #1 donned (put on) a new pair of gloves without performing hand hygiene. HK #1 entered resident room [ROOM NUMBER] with a bottle containing a purple-colored disinfectant solution labeled (BNC-15) and began spraying the entire surface of the sink area. HK #1 picked up articles from the floor around the resident's bed. She started rearranging personal items on the resident's bedside table. HK #1 returned to her cart, removed her gloves and donned a