STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065307	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, and interview, the facility failed to provide choices for preference of bathing schedule for two (#4 and #1) of six residents reviewed for self-determination out of 10 sample residents. Specifically, the facility failed to ensure Residents #1 and Resident #4, who were dependent on staff for care, received regular bathing in accordance with preferences and plan of care. Findings include: I. Facility policy and procedure The Resident Self Determination policy, revised August 2022, was provided by the director of nursing (DON) on 6/11/25 at 6:05 p.m. The policy read in part, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities, schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and care plans including daily routine, such as sleeping and waking, eating, exercise, bathing schedules and personal care needs such as bathing methods and grooming styles and dress. The Activities of Daily Living (ADL), Supporting policy, revised 2018, was provided by the DON on 6/11/25 at 6:05 p.m. The policy read in part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care). If residents with cognitive impairments or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having other staff members speak with the resident may be appropriate. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention to improve or minimize a residents functional abilities will be in accordance with the residents assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated and revised as appropriate. II. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), the diagnoses included basal skin carcinoma of the skin, vascular dementia, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side (limited movement on the left side due to a stroke), cerebral infarction (stroke), weakness and cognitive communication deficit. The 4/14/24 minimum data set (MDS) assessment identified Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The assessment documented Resident #4 was dependent on staff for most of her ADLs to include bathing. The MDS assessment indicated Resident #4 had rejections of care behaviors. B. Resident interview Resident #4 was interviewed with her representative on 6/10/25 at 2:02 p.m. Resident #4 said she preferred to shower twice a week on Monday and Thursday or Friday. She said she did not always get her showers and she was not allowed to refuse her showers. Resident #4's representative said Resident #4 was lucky if she got a shower once a week. She said the facility told her that was told Resident #4 would often refuse her showers. She said she had asked staff to call her if Resident #4 refused the shower, but she had not received any calls from the facility regarding bathing refusals. C. Record review Resident #4's ADL care plan, initiated 11/20/24, identified Resident #4 had limitations in her ability to perform her ADLs related to her impaired mobility due to her cerebrovascular accident (CVA) with left sided hemiparesis. According to the care plan, Resident #4 preferred showers twice a week during the day shift and required extensive assistance of one to two staff with bathing. -The ADL care plan did not identify Resident #4 refused bathing opportunities or interventions on her to address her refusals. Resident #1's bathing record from 4/15/25 to 6/11/25 was provided by the DON on 6/11/25 at 2:09 p.m. The April 2025 bathing record indicated Resident #4 received one shower (4/25/25) in April 2025 and refused one shower (4/18/25) between 4/15/25 and 4/29/25. The April 2025 bathing record identified Resident #4 receive three showers/bed baths out of 16 opportunities for bathing. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2025 bathing record documented the resident refused a shower on 5/16/25. The May 2025 bathing record identified Resident #4 receive six out of 31 opportunities for bathing. The May 2025 and June 2025 bathing records between 5/20/25 and 6/2/25, did not indicate Resident #4 received or refused another bathing opportunity until 6/2/25. A review of Resident #4's progress note, dates documented on 5/25/25, documented Resident #4 refused her last shower day. -The 5/25/25 progress note did not document when the resident refused her shower or why she refused her shower. The 5/29/25 behavior note documented Resident #4 requested a shower and was out on the shower list for 5/29/25. -The note did not identify that she received a shower on 5/29/25. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged on 2/1/25. According to the February 2025 CPO, the diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side (limited movement on one side of the body due to a stroke), weakness, dysphagia following other cerebral vascular disease (difficulty swallowing), other lack of coordination, unsteadiness on feet, cognitive communication deficit and aphasia following cerebral infarction (difficulty talking). The 2/28/25 MDS assessment revealed the resident had some difficulty in new situations that impacted independent decision making. According to the staff assessment mental status the resident did not have memory impairment. Resident #1 required partial to moderate staff assistance with most of her ADLs to include bathing. The MDS assessment indicated Resident #1 did not have rejections of care. B. Resident representative interview Resident #1's representative was interviewed on 6/11/25 at 11:15 a.m. via phone. The representative said Resident #1 had a shower everyday when she was at home. He said Resident #1 wanted a shower at least every other day while she was at the facility. He said Resident #1 did not receive showers every other day. He said she did not receive more than one shower a week while at the facility. He said her hair was dirty and she had an odor. Resident #1's representative said he sometimes had to take her home on the weekends to bathe her while she was at the facility. He said when he complained about the lack of bathing to the facility staff, he was told that people over the age of 60 did not like bathing everyday. C. Record review (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan did not identify Resident #1 had an ADL specific care plan. Review of the comprehensive care plan did not reveal the resident required staff assistance with her ADL's. The care plan did not identify Resident #1 wanted to be bathed every other day. The care plan did not identify that the resident refused opportunities to bathe. The 11/21/24 admission data collection assessment identified Resident #1 wanted a shower every other day in the mornings. Resident #1's bathing record from 1/1/25 to 1/1/25 was provided by the DON on 6/11/25 at 2:09 p.m. The bathing record identified Resident #1 needed partial to total physical assistance from staff for her bathing. In January 2025 she received a shower on 1/2/25, 1/16/25, 1/20/25, 1/22/25, 1/27/25 and 1/30/25. The January 2025 EMR indicated Resident #1 receive six out of 31 opportunities for bathing. IV. Staff education Staff education for bathing documentation and the procedure to address bathing refusals was provided by the assistant director of nursing (ADON) on 6/11/25 at 5:05 p.m. The staff education was attended by 21 staff members on 6/4/25 and five staff members on 6/11/25 (during the survey). The education identified certified nurse aides (CNA) must report when residents refuse showers to the nurses. The nurses needed to determine the root cause of the resident's refusal if possible and offer interventions to help ensure the shower was completed. According to the provided education, if a resident continued to refuse a bathing opportunity, the nurse must notify the resident's representative and the resident's physician. The nurses needed to document the refusal in a progress note. The education indicated the refusal of a shower/bath must be documented in the resident's care plan. V. Staff interviews CNA #1 was interviewed on 6/11/25 at 4:13 p.m. CNA #1 said if a resident received a shower/bath or if they refused it should be documented in the bathing record. She said the staff should make three attempts to offer the shower and let the nurse know. She said staff should also document why the resident refused. The DON was interviewed on 6/11/25 at 4:40 p.m. The DON said residents received bathing opportunities twice a week unless they identified they preferred more or less showers/baths in a week. She said residents were asked their bathing preferences on admissions and throughout their staff at the facility. She said some of the residents wanted a shower daily and other residents wanted only a shower weekly. She said the facility tried to follow the residents' preferences for showering. The DON said if a resident refused a shower, staff should offer the shower three times that day and document the residents refusal. She said the nurse should encourage the resident to shower and determine why the resident continued to refuse the shower. The DON said the nurse should contact the POA in efforts to encourage the resident to shower and notify the resident's physician. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said in May 2025, she noticed holes in residents' bathing documentation and felt staff needed increased education to ensure showers were documented and offered according to the residents'shower schedule and their preferences. She said she did verbal education with staff in May 2025 and the ADON formalized the education in June 2025. The DON said she wanted to make sure staff identified the root cause of the refusals so interventions could be put in place. The DON said Resident #4 frequently refused her showers but there was limited documentation identifying her refusals and her care plan did not identify interventions to address the refusals. The DON said documentation indicated Resident #4 was not offered bathing opportunities for over a week at time. She said she did not know if the resident was offered to bathe but refused and the staff did not document it appropriately . The DON said Resident #1 was scheduled to receive showers on Mondays and Thursdays. She said the resident's shower schedule did not identify the resident preferred to be showered every other day. The DON said the resident's EMR indicated she was not offered bathing opportunities for long periods at a time. She said she did not know why the resident was not offered showers routinely and as preferred. The DON said Resident #1's shower preference might have changed while she was at the facility but nothing was shown in the record to identify she wanted less showers or frequently refused showers. The DON said she would continue to provide staff education.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on record review and interviews, the facility failed to ensure a copy of medical records were provided timely for two (#2 and #1) of three residents out of 10 sample residents. Specifically, the facility failed to ensure medical records were provided timely upon request to the representatives of Resident #2 and Resident #1. Findings include: I. Facility policy and procedure The Release of Information policy, revised November 2009, was provided by the director of nursing (DON) on 6/11/25 at 6:05 p.m. The policy read in pertinent part, The resident may initiate a request to release such information contained in his or her records and charts to anyone he or she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative. A resident may obtain photocopies of his or her records by providing the facility with at least a 48 hour advance notice of such request. II. Residents' representative interviews Resident #2's representative was interviewed on 6/10/25 at 4:13 p.m. The representative said she requested Resident #2 medical records at the end 2024 and it took a week for the facility to provide them to her. She said she felt the medical records should have been provided to her within a couple days. She said she called the former social service director (SSD) a couple times to remind the facility of the request before she received them. Resident #1's representative was interviewed on 6/11/25 at 11:15 a.m. The representative said Resident #1 was at the facility from November 2024 through January 2025 and discharged on 2/1/25. Resident #1's representative said he requested the resident's medical record from the facility in spring 2025 for social security requirements. Resident #1's representative said he did not receive the medical records for over a week after he requested them. II. Record review The authorization for release of protected health information (PHI) forms for Resident #2 and Resident #1 were provided by the former medical records director (FMRD) on 6/11/25 at 4:17 p.m. The PHI authorization release for Resident #2 identified the request for the resident's record was on 9/10/24. The form did not identify when the representative received the records. Review of the provided forms did not identify another PHI authorization release request at the end of 2024 as identified by Resident #2's representative. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PHI authorization release form for Resident #1 identified a request for the resident's record on 4/2/25. The form did not identify when the representative received the records or when the records were sent to the representative. III. Staff interviews The FMRD was interviewed on 6/11/25 at approximately 3:30 p.m. The FMRD said when a resident or their representative requested medical records, they needed to submit an authorization for release of the medical records. The FMRD said the facility had 30 days to gather the records and send them to the requester. The FMRD was interviewed again on 6/11/25 at 4:17 p.m. The FMRD said Resident #1's medical records were requested by her representative on 4/2/25. She said the representative said he needed the medical records right away. The FMRD said she prioritized the request for Resident #1's medical records by providing them to Resident #1's representative within two weeks of the request. The FMRD said Resident #2's representative requested Resident #2's medical records on 9/10/24. She said she remembered she provided the representative the medical records on the day of the request. She said she did not find any other request for medical records for Resident #2. The DON was interviewed on 6/11/25 at 6:05 p.m. The DON said she would make sure the FMRD was aware of the facility's expectation of providing residents and/or the residents in 48 hours of the request.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for two (#4 and #1) of three residents out of 10 sample residents. Specifically, the facility failed to: -Provide timely restorative services, as was care planned and recommended, for Resident #4; and, -Offer and provide a restorative service program for Resident #1 to help maintain the resident's function after the resident was discharged from therapy services. Findings include: I. Facility policy and procedure The Functional Impairment policy, revised September 2012, was provided by the director of nursing (DON) on 6/11/25 at 6:05 p.m. The policy read in pertinent part, Upon admission to the facility, at any time a significant change of condition occurs, and periodically during the resident's stay, the physician and staff will assess the resident's physical condition and functional status. A physician, nurse or therapist may initiate screening for the potential to benefit from rehabilitation services such as physical and occupational therapy. Following the screening, the therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation from unskilled therapy, as for example restorative nursing services that can be provided by caregivers or exercises with which family members can assist. In conjunction with the physician and staff, therapists will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcome efficiently using available resources. II. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included basal skin carcinoma of the skin, vascular dementia, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side (limited movement on the left side due to a stroke), cerebral infarction (stroke), weakness and cognitive communication deficit. The 4/14/24 minimum data set (MDS) assessment identified Resident #4 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The assessment documented Resident #4 was dependent on staff for most of her activities of daily living (ADL). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident and resident's representative interview Resident #4 was interviewed along with her representative on 6/10/25 at 2:02 p.m. Resident #4 said she recently fell out of bed. Resident #4's representative said Resident #4 had not been evaluated by therapy and she had not received restorative services even though she requested Resident #4 to be screened for services in May 2025. She said she was told by the facility that there were no restorative services available at the time, but the facility was working on hiring someone. C. Record review The restorative program care plan, initiated 1/9/23 and revised 6/11/25 (during the survey), directed staff to provide active range of motion (AROM) for Resident #4 to the right side of her body and passive (PROM) to the left side of her body. Interventions included staff providing and encouraging the resident with AROM exercises and AROM ADL self-care activities as tolerated (initiated 10/16/24) and a restorative nurse aide (RNA) was to encourage and assist Resident #4 with (PROM) to her upper and lower extremities as tolerated (initiated 10/10/24 and revised 6/11/25, during the survey). The fall and behavior care plan, revised 6/10/25, documented Resident #4 had a history of falling/removing herself from her bed. The resident's most recent fall (6/1/25) resulted in skin tear. According to the care plan, Resident #4 stated she climbed out of bed because staff was not paying enough attention to her. The intervention, initiated 6/3/25, directed staff to offer the resident a restorative program. The 6/3/25 interdisciplinary team (IDT) note documented the IDT reviewed Resident #4's 6/1/25 fall and recommended a physical therapy (PT) and occupational therapy (OT) evaluation for a restorative program for Resident #4. Review of Resident #4's May 2025 and June 2025 progress notes did not reveal documentation to indicate Resident #4 was on a restorative services program. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged home on 2/1/25. According to the February 2025 CPO, diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side (limited movement on one side of the body due to a stroke), weakness, dysphagia following other cerebral vascular disease (difficulty swallowing), other lack of coordination, unsteadiness on feet, cognitive communication deficit and aphasia following cerebral infarction (difficulty talking). The 2/28/25 MDS assessment revealed the resident had some difficulty in new situations that impacted independent decision making. According to the staff assessment for mental status, the resident did not have memory impairment. Resident #1 required partial to moderate staff assistance with most of her ADLs. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident's representative interview Resident #1's representative was interviewed on 6/11/25 at 11:15 a.m. via phone. The representative said Resident #1 had a decline in function before she was discharged on 2/1/25. The resident's representative said he was having to pay out-of-pocket for her PT/OT and speech therapy services. He said Resident #1 was not offered restorative services and he was not informed that restorative nursing was an option for Resident #1 to help maintain function with range of motion through the nursing program. He said he was only informed of services he would have to pay out-of-pocket for. C. Record review The fall care plan, initiated 12/8/24, directed staff to encourage Resident #1 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. The 1/11/25 physical therapy encounter note documented Resident #1 was discharged from PT due to a financial choice and slow progress. The 1/24/25 OT discharge summary identified Resident #1 was discharged from therapy related to an existing co-pay and the resident/responsible party declined treatment. -The OT discharge summary did not identify if a restorative program through the nursing department was recommended or available for Resident #1. IV. Staff interviews The DON and the assistant director of nursing (ADON) were interviewed together on 6/11/25 at 3:29 p.m. The DON said the facility had not had a restorative program for several months that could offer residents passive and active range of motion. She said the only restorative programming that the facility was able to offer for residents was meal assistance. She said the facility had just hired a restorative nurse aide and would now be able to start a complete restorative program. She said the facility's restorative program was currently being set up and they would soon be able to offer restorative services again. The ADON said after Resident #4 fell on 6/1/25, the IDT recommended OT to evaluate the resident for the restorative services program. She said there was some miscommunication between the IDT and OT. The ADON said OT did not evaluate Resident #4 when requested on 6/3/25 after the resident fell. The ADON said the resident would be immediately evaluated by OT and the facility would follow up with Resident #4 and her representative. The ADON was interviewed again on 6/11/25 at 4:28 p.m. The ADON said OT had just evaluated Resident #4 (on 6/11/25) and felt OT was not appropriate and recommended a restorative services program for the resident. The DON was interviewed again on 6/11/25 at 6:35 p.m. The DON said residents would usually be offered restorative services through the nursing department after discharging from OT and PT to help continue their functional goals and progress achieved with therapy. She said Resident #1 was not offered restorative services after she completed therapy in January 2025 because the facility did not have a restorative program at that time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Facility follow-up The 6/11/25 OT evaluation and plan of treatment documented Resident #4 was not appropriate for OT at the time of the 6/11/25 OT evaluation. According to the evaluation, Resident #4 would benefit from a restorative services program five to seven days a week for four weeks with active and passive range of motion. The 6/11/25 restorative services program note documented Resident #4's representative was contacted on 6/11/25 and informed that Resident #4 would be added to the facility's restorative program for active and passive range of motion.