

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711</b></p> <p>Based on record review and interviews, the facility failed to ensure two (#2 and #3) of five residents out of nine sample residents were kept free from abuse.</p> <p>Specifically, the facility failed to ensure Resident #2 was kept free from abuse by Resident #3.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy and procedure, revised October 2024, was provided by the nursing home administrator (NHA) on 10/23/24 at 12:33 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.</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and resident to resident altercations.</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to, responding immediately to protect the alleged victim and integrity of the investigation, examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed, increased supervision of the alleged victim and residents, room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator, protection from retaliation, providing emotional support and counseling to the resident during and after the investigation, as needed and revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>II. Incident of physical abuse between Resident #2 and Resident #3 on 3/21/24</p> <p>(continued on next page)</p>

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:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 3/21/24 nursing progress note documented Resident #2 informed the nurse that Resident #3 pushed him on the chest and knocked him backwards, causing him to fall and hit his head on the floor. Upon a nursing assessment, a hematoma (pool of clotted blood that forms in an organ, tissue, or body space caused by a broken blood vessel) was identified on the right side of Resident #2's head.</p> <p>The progress note further documented Resident #3 indicated that Resident #2 came into his room and punched him in the left eye. Resident #3 made a gesturing motion to indicate that he pushed Resident #2 which caused Resident #2 to fall to the floor. Resident #3 said he went boom and then pointed to the floor. The nurse assessment revealed a small 1 centimeter (cm) by 1 cm hematoma to Resident #3's left lower eye and an abrasion to his left cheek.</p> <p>The 3/21/24 situation, background and review (SBAR) assessment documented a change in condition to the appearance of Resident# 3 with the noted bruise to the left lower eye and an abrasion. The interventions included frequent checks every 15 minutes, neurological checks and to separate the residents.</p> <p>The 3/21/24 abuse investigation documented Resident #2 said Resident #3 pushed him on his chest, knocked him down on his back and made him hit his head on the ground. Upon assessment completed by the nurse, Resident #2 was noted to have a small hematoma to the right side of the head.</p> <p>Resident #3 said Resident #2 entered his room and hit him in the face, for which Resident #3 responded by pushing Resident #2 in the chest, causing him to fall to the ground. Upon assessment, Resident #3 sustained a bruise and abrasion to the right eye.</p> <p>-The facility documented that the physical abuse was unsubstantiated because there was not a witness to the altercation, however both Resident #2 and Resident #3 had corresponding injuries that were consistent with their story.</p> <p>III. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.</p> <p>The 3/21/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He was independent with all activities of daily living (ADL).</p> <p>B. Record review</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The behavioral care plan, revised on 10/22/24 (during the survey), documented Resident #2 had a behavior problem of sexually inappropriate behaviors and touching other residents. He sometimes thought other residents were his wife. Interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness of medications, behavioral monitoring every shift, providing firm redirection and two person care, one-to-one supervision for the resident every shift, notifying the unit manager or director of nursing (DON) and the NHA if Resident #2 was seen alone without one-to-one supervision and if any inappropriate behavior occurred and providing a program of activities of interest to the resident.</p> <p>IV. Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age 68, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included dementia with moderate agitation, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.</p> <p>The 6/11/24 MDS assessment revealed the resident was moderately cognitive impairment with a BIMS score of four out of 15. He required extensive to moderate assistance with ADLs.</p> <p>B. Record review</p> <p>The behavioral care plan, initiated on 5/31/23 and revised on 11/29/23, documented Resident #3 had episodes of being physically combative and abusive when he felt other residents were too close to him or invading his space.</p> <p>Resident #3 had hit or pushed others to get them away from him. Interventions included documenting behavioral episodes, maintaining a calm, slow and understanding approach, monitoring and reporting an increase in behaviors, monitoring Resident #3 when other residents were in close proximity as necessary and removing other residents if needed and notifying the physician and responsible party of episodes of aggression and abusive behavior.</p> <p>V. Staff interviews</p> <p>The NHA and the regional clinical consultant (RCC) were interviewed on 10/23/24 at 11:17 a.m. The NHA said he was the abuse coordinator for the facility and was responsible for directing the investigation for any allegation of abuse. He said physical abuse occurred when there was actual physical contact made.</p> <p>The NHA said he directed the physical abuse investigation between Resident #2 and Resident #3 on 3/21/24. He said he thought that the conclusion of unsubstantiated had been reached because there was no staff witness of the event.</p> <p>The NHA said, upon review of the investigation and the physical assessments conducted at the time of the incident, both resident's sustained injuries that were consistent with their version of the event that occurred on 3/21/24. He said based on his review of the investigation that day (10/23/24), he should have substantiated that physical abuse had occurred between Resident #2 and Resident #3 on 3/21/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51711</p> <p>Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for two (#2 and #8) of five residents reviewed for abuse out of nine sample residents.</p> <p>Specifically, the facility failed to report two incident of potential sexual abuse involving Resident #2 and Resident #8 to the State Agency.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Response policy and procedure, revised October 2024, was provided by the nursing home administrator (NHA) on 10/23/24 at 12:33 p.m. It revealed in pertinent part, Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies ( law enforcement when applicable) within specified times frames is required for all types of abuse, neglect, misappropriation of resident property and exploitation (including injuries of unknown origin), and thoroughly investigated by facility administrator. Findings of investigations are documented and reported.</p> <p>The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility.</p> <p>II. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.</p> <p>The 3/21/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He was independent with all activities of daily living (ADL).</p> <p>B. Record review</p> <p>The behavioral care plan, revised on 10/22/24 (during the survey), documented Resident #2 had a behavior problem of sexually inappropriate behaviors and touching other residents. He sometimes thought other residents were his wife.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness of medications, behavioral monitoring every shift, providing firm redirection and two person care, one-to-one supervision for the resident every shift, notifying the unit manager or director of nursing (DON) and the NHA if Resident #2 was seen alone without one-to-one supervision and if any inappropriate behavior occurred and providing a program of activities of interest to the resident.</p> <p>III. Resident #8</p> <p>A. Resident status</p> <p>Resident #8, age less than 65, was admitted on [DATE]. According to the 9/3/24 CPO, diagnoses included bipolar disorder, dementia with psychotic disturbance, other symptoms and signs involving cognitive functions and awareness, unspecified psychosis not due to a substance or known physiological condition and unspecified convulsions</p> <p>The 9/18/24 MDS assessment revealed the resident had short and long-term memory deficits and her daily decision making skills were severely impaired based on the staff assessment for mental status. She was dependent on staff for all ADLs.</p> <p>B. Record Review</p> <p>The care plan, revised on 9/23/24, documented that Resident #8 had altered cognition related to dementia with psychotic disturbance, bipolar disorder and psychosis manifested by impaired short and long term memory, safety awareness and decision making. The resident had a communication deficit that indicated the inability for Resident #8 to make her needs known.</p> <p>IV. Incident involving Resident #8 on 9/14/24</p> <p>The 9/14/24 nursing progress note documented that at approximately 5:37 p.m., Resident #2 had used his hands to hold Resident #8's hands. Resident #2 kissed Resident #8's hands and then sat down next to her for about 45 minutes. Resident #2 was later observed going into Resident #8's room to see her.</p> <p>-The facility was unable to provide documentation that the incident had been investigated for potential sexual abuse.</p> <p>Cross reference F610 for failure to investigate potential abuse.</p> <p>-The facility was unable to provide documentation that the incident of potential sexual abuse was reported to the State Agency.</p> <p>V. Incident involving Resident #8 on 9/17/24</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 9/17/24 nursing progress note documented the nurse observed Resident #2 holding and rubbing the hand of the Resident #8. The nurse tried to redirect Resident #2 a few times. Resident #2 got upset and stated she is my wife. A certified nurse aide (CNA) observed Resident #2 touching Resident #8's leg and Resident #2 refused to move away from Resident #8. Resident #2 was separated from Resident #8 and a CNA arranged the table so that Resident #2 would not be able to come near her. The nurse practitioner visited on 9/17/24 and was provided an update of the incident.</p> <p>-The facility was unable to provide documentation that the incident had been investigated for potential sexual abuse.</p> <p>-The facility was unable to provide documentation that the incident of potential sexual abuse was reported to the State Agency.</p> <p>VI. Staff interviews</p> <p>The NHA was interviewed on 10/22/24 at 2:03 p.m. The NHA said the incidents involving Resident #2 and Resident # 8 on 9/14/24 and 9/17/24 should have been reported by staff and to the State Agency.</p> <p>The regional clinical consultant (RCC) was interviewed on 10/23/24 at 9:35 a.m. The RCC said an additional action item had been added to the facility's recent performance improvement plan (PIP) on 10/22/24 (during the survey) following the identification of the two unreported incidents involving Resident #2 and Resident #8. The RCC said the interdisciplinary team (IDT) would be reviewing progress notes five times a week to ensure no unreported incidents of potential abuse were documented.</p> <p>The NHA and the RCC were interviewed together on 10/23/24 at 10:53 a.m. The RCC said, prior to the survey, the facility had realized that facility staff had an issue with the understanding of what constituted neglect, abuse or exploitation and what a thorough investigation process should look like, including interviewing and reporting. She said a PIP was initiated on 10/11/24.</p> <p>-However, according to the RCC's previous interview (see above), the facility had implemented a new action item to the PIP, during the survey.</p> <p>The NHA said there were two abuse allegations involving Resident #2 which were not reported timely. The NHA said the abuse allegations were reported to the State Agency on 10/22/24 (during the survey). The NHA said abuse should be reported/investigated and responded to within 24 hours unless serious injury occurred. He said if a serious injury occurred, potential abuse must be reported within two hours.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711</b></p> <p>Based on record review, the facility failed to investigate incidents of abuse involving two (#2 and #8) of five residents reviewed for abuse out of nine sample residents.</p> <p>Specifically, the facility failed to conduct investigations of two incidents of potential sexual abuse involving Resident #2 and Resident #8.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy and procedure, revised October 2024, was provided by the nursing home administrator (NHA) on 10/23/24 at 12:33 p.m. It revealed in pertinent part, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, including those that may represent resident to resident abuse, and reported to the administrator immediately.</p> <p>II. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.</p> <p>The 3/21/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He was independent with all activities of daily living (ADL).</p> <p>B. Record review</p> <p>The behavioral care plan, revised on 10/22/24 (during the survey), documented Resident #2 had a behavior problem of sexually inappropriate behaviors and touching other residents. He sometimes thought other residents were his wife.</p> <p>Interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness of medications, behavioral monitoring every shift, providing firm redirection and two person care, one-to-one supervision for the resident every shift, notifying the unit manager or director of nursing (DON) and the NHA if Resident #2 was seen alone without one-to-one supervision and if any inappropriate behavior occurred and providing a program of activities of interest to the resident.</p> <p>III. Resident #8</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #8, age less than 65, was admitted on [DATE]. According to the 9/3/24 CPO, diagnoses included bipolar disorder, dementia with psychotic disturbance, other symptoms and signs involving cognitive functions and awareness, unspecified psychosis not due to a substance or known physiological condition and unspecified convulsions.</p> <p>The 9/18/24 MDS assessment revealed the resident had short and long-term memory deficits and her daily decision making skills were severely impaired based on the staff assessment for mental status. She was dependent on staff for all ADLs.</p> <p>B. Record Review</p> <p>The care plan, revised on 9/23/24, documented that Resident #8 had altered cognition related to dementia with psychotic disturbance, bipolar disorder and psychosis manifested by impaired short and long term memory, safety awareness and decision making. The resident had a communication deficit that indicated the inability for Resident #8 to make her needs known.</p> <p>IV. Incident involving Resident #8 on 9/14/24</p> <p>The 9/14/24 nurse progress note documented that at approximately 5:37 p.m. Resident #2 had used his hands to hold Resident #8's hands. Resident #2 kissed Resident #8's hands and then sat down next to her for about 45 minutes. Resident #2 was later observed going into Resident #8's room to see her.</p> <p>An investigation related to the incident on 9/14/24 was requested on 10/22/24, during the survey process.</p> <p>-The facility was unable to provide documentation that an investigation had been completed following the abuse incident with Resident #2 and Resident #8 on 9/14/24.</p> <p>V. Incident involving Resident #8 on 9/17/24</p> <p>The 9/17/24 nurse progress note documented the nurse observed Resident #2 holding and rubbing the hand of the Resident #8. The nurse tried to redirect Resident #2 a few times. Resident #2 got upset and stated she is my wife.</p> <p>A certified nurse assistant (CNA) observed Resident #2 touching Resident #8's leg and Resident #2 refused to move away from Resident #8. Resident #2 was separated from Resident #8 and a CNA arranged the table so that Resident #2 would not be able to come near her. The nurse practitioner visited on 9/17/24 and was provided an update of the incident.</p> <p>An investigation related to the incident on 9/17/24 was requested on 10/22/24, during the survey process.</p> <p>-The facility was unable to provide documentation that an investigation had been completed following the incident between Resident #2 and Resident #8 on 9/17/24.</p> <p>VI. Staff interviews</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Boulder Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 Mesa Dr Boulder, CO 80304	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA was interviewed on 10/22/24 at 2:03 p.m. The NHA said the incidents involving Resident #2 and Resident # 8 on 9/14/24 and 9/17/24 should have been investigated.</p> <p>The regional clinical consultant (RCC) was interviewed on 10/23/24 at 9:35 a.m. The RCC said an additional action item to the facility's recent performance improvement plan (PIP) on 10/22/24 (during the survey) following the identification of two unreported incidents involving Resident #2 and Resident #8. The RCC said the interdisciplinary team (IDT) would be reviewing progress notes five times a week to ensure no unreported incidents of potential abuse were documented.</p> <p>The NHA and regional clinical consultant (RCC) were interviewed on 10/23/24 at 10:53 a.m. The RCC said, prior to the survey, the facility had realized that facility staff had an issue with the understanding of what constituted neglect, abuse or exploitation, the thorough investigation process including interviewing and reporting, and a performance improvement plan was initiated on 10/11/24.</p> <p>-However, according to the RCC's previous interview (see above), the facility had implemented a new action item to the PIP, during the survey.</p> <p>The NHA said all incidents of abuse or allegations of abuse should be investigated timely and he had initiated the investigation process of the 9/14/24 and 9/17/24 incidents and reported the incidents to the State Agency as well as contacted law enforcement.</p>