

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 02/04/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166</p> <p>Based on record review and interviews, the facility failed to ensure one (#1) of five residents was kept free from abuse out of five sample residents.</p> <p>Specifically, the facility failed to ensure Resident #1 was kept free from sexual abuse by Resident #2.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect and Exploitation policy and procedure, revised 2024, was provided by the nursing home administrator (NHA) on 2/4/25 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 sexual abuse between Resident #1 and Resident #2 on 1/4/25</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 1/4/25 abuse investigation documented Resident #1 had wandered into Resident #2's room and fell asleep on Resident's #2's roommate's bed. When Resident #2 returned to his room, he laid down next to Resident #1 and touched her in a sexual manner.</p> <p>During the rounds, certified nurse aide (CNA) #1 found the residents and immediately separated them. Both residents were placed on 15-minute checks. Resident #2 was placed on one-to-one observations. Later the same day, Resident #2 was moved to a unit on the second floor where his one-to-one continued and he was around more alert and oriented residents.</p> <p>The facility investigation documented that the sexual abuse was substantiated.</p> <p>II. Resident #2 - assailant</p> <p>A. Resident status</p> <p>Resident #2, age greater than 75, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.</p> <p>The 12/13/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairments per staff assessment. He required minimal assistance with all activities of daily living (ADL), and ambulated with a walker.</p> <p>The assessment indicated the resident did not have physical or verbal behaviors towards other residents.</p> <p>B. Record review</p> <p>The behavioral care plan, revised on 1/7/25, documented Resident #2 had displayed sexually inappropriate behaviors and touched other residents. 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, providing 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 #1 - victim</p> <p>A. Resident status</p> <p>Resident #1, age 72, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia with behavioral disturbance and major depressive disorder.</p> <p>The 12/2/24 MDS assessment revealed the resident had severe cognitive impairments per staff assessment. She required supervision and minimal assistance with ADLs. She ambulated without assistance.</p> <p>B. Record review</p> <p>(continued on next page)</p>		

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<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, initiated on 12/30/24 and revised on 1/6/25, documented Resident #1 was at risk for behavioral symptoms such as getting in other resident's beds or biting once agitated due to dementia. Interventions included maintaining a calm and slow approach, observing and documenting changes in behavior, providing reminders and checking on the resident every 15 minutes.</p> <p>A 1/4/25 nursing progress note documented Resident #1 was sleeping in Resident #2's roommate's bed. Resident #2 was noted to have his hands in Resident #1's pants pocket and was touching her on her hip and thigh. The residents were immediately separated.</p> <p>IV. Staff interviews</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 2/3/25 at 10:40 a.m. LPN #1 said she was the nurse working on the unit with Resident #1. She said she was an agency nurse and did not know much about Resident #1. She said Resident #2 did not reside in the same unit. She said the unit did not have any residents with sexually inappropriate behaviors.</p> <p>CNA #2 was interviewed on 2/3/25 at 11:05 a.m. CNA #2 said Resident #1 liked to walk and she occasionally entered rooms of other residents where she would fall asleep. She said Resident #1 was not aggressive and easily redirectable. She said the staff checked on her every 15 minutes, however she was very quick and could be anywhere at any time. CNA #2 said Resident #2 no longer resided on the same unit as Resident #1.</p> <p>LPN #2 was interviewed on 2/3/25 at 4:30 pm. LPN #2 said she was the unit manager for the unit where Resident #1 currently resided. She said Resident #1 wandered around the unit and occasionally entered other residents' rooms. She said the staff checked on the resident every 15 minutes to ensure that she was not in someone else's room.</p> <p>LPN #2 said after the incident on 1/4/25, Resident #2 was moved to the second floor where he could be around more alert and oriented residents. She said in addition, Resident #2 was placed on one-to-one monitoring for sexually inappropriate behaviors.</p> <p>The NHA was interviewed on 2/3/25 at 4:50 p.m. The NHA said Resident #2 had a history of sexually inappropriate behaviors and was previously placed on one-to-one monitoring in the past. He said after being on one-to-one for several weeks, he did not display sexually inappropriate behaviors, his medications were adjusted and he was removed from one-to-one monitoring. The NHA said after the incident on 1/4/25, the interdisciplinary (IDT) team decided that one-to-one monitoring was necessary for Resident #2 and it was initiated for an indefinite period. He said, Resident #2 was moved to a different unit where he would be around more alert and oriented residents.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166</p> <p>Based on observations, record review and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being for one (#1) of five residents out five sample residents.</p> <p>Specifically, the facility failed to develop and implement effective dementia management focused interventions to prevent Resident #1 from wandering into other resident's rooms.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Dementia Care policy and procedure, undated, was provided by the nursing home administrator (NHA) on 2/4/25 at 12:33 p.m. It read in pertinent part, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being.</p> <p>The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 72, was admitted on [DATE]. According to the February 2025 computerized physicians orders (CPO), diagnoses included dementia with behavioral disturbance and major depressive disorder.</p> <p>The 12/2/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments per staff interview. She required supervision and minimal assistance with activities of daily living (ADLs). She ambulated without assistance.</p> <p>B. Record review</p> <p>The behavioral care plan, initiated on 12/30/24 and revised on 1/6/25, documented Resident #1 was at risk for behavioral symptoms such as getting in other resident's beds or biting once agitated due to dementia. Interventions included maintaining a calm and slow approach, observing and document changes in behavior, providing reminders and checking on the resident every 15 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 1/4/25 nursing progress note documented Resident #1 was sleeping in Resident #2's roommate's bed. Resident #2 was noted to have his hands in her pants pocket and touching her on her hip and thigh. Resident #1 showed no fear or anxious behavior. Resident #1 appeared comfortable. The residents were immediately separated.</p> <p>Cross reference F600 failure to protect Resident #1 from sexual abuse.</p> <p>A 12/26/24 nursing note documented Resident #1 was lying down in the (other) resident bed. The resident tried to get Resident #1 out of her bed and Resident #1 bit her on her left forearm. Residents were separated. Resident #1 was placed on 15 min checks.</p> <p>-No person centered dementia interventions were provided to Resident #1.</p> <p>C. Observations</p> <p>On 2/3/25 at 10:30 a.m. observations on the first floor unit were conducted. Resident #1 was not in her room. The resident's room did not have any personal pictures, items or signs to help the resident identify her room.</p> <p>At 10:35 a.m. Resident #1 was located by certified nurse aide (CNA) #2. Resident was asleep in another resident's room. The room belonged to two gentlemen who were not in the room. Resident #1 was woken up and taken to her room by CNA #2.</p> <p>III. Staff interviews</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 2/3/25 at 10:25 a.m. LPN #1 said she was an agency nurse and did not know much about Resident #1. She said she could look up the care plan in her medical record. She said she did not know what Resident #1 looked like or where she was at the moment. She said she would ask the CNAs, because they knew residents well.</p> <p>CNA #2 was interviewed on 2/3/25 at 10:30 a.m. She said Resident #1 was not in the common area and not in her room. She said the resident probably fell asleep in someone else's room (see observations above).</p> <p>CNA #2 was interviewed a second time on 2/3/25 at 11:05 a.m. She said Resident #1 liked to walk and she occasionally entered rooms of other residents where she would fall asleep. She said Resident #1 was not aggressive and easily redirectable. She said the staff checked on her every 15 minutes, however she was very quick and could be anywhere at any time. She said she was aware of one altercation that Resident #1 had with other residents that occurred on 1/4/25.</p> <p>LPN #2 was interviewed on 2/3/25 at 4:30 pm. LPN #2 said she was the unit manager for the unit where Resident #1 currently resided. She said Resident #1 wandered around the unit and occasionally entered other resident's rooms. She said the staff checked on the resident every 15 minutes to ensure that she was not in someone else's room. She said some rooms had a stop sign at the entrance to prevent wandering residents from wandering.</p> <p>(continued on next page)</p>		

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