STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065052	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Post Acute	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on record review and interviews, the facility failed to ensure two (#2 and #3) of four residents were free from abuse out of 10 sample residents. Specifically, the facility failed to ensure Resident #2 and Resident #3 were free from physical abuse by each other. On 4/16/25 Resident #2 attempted to strike Resident #3. Resident #3 responded by grabbing Resident #2. Both residents fell to the ground. Resident #3 sustained a left humerus (shoulder) fracture. Resident #2 sustained bruising to his arm and an abrasion to his back. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, 2024, was provided by the nursing home administrator (NHA) on 5/7/25 at 10:15 a.m. via email. 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, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. (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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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Serious bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization , or physical rehabilitation. II. Physical abuse between Resident #2 and Resident #3 on 4/16/25 A. Facility investigation The 4/16/25 facility investigation was provided by the NHA on 5/12/25 at 9:15 a.m. The investigation documented Resident #2 and Resident #3 resided on a secured unit. Resident #2 had severe cognitive impairment, impaired communication ability and weighed 150.6 pounds. Resident #3 was cognitively intact and had delusions and hallucinations in regards to self and others. Resident #3 weighed 268.2 pounds, which was over a 100 pound difference between the two residents. The investigation documented that on 4/16/25 at approximately 4:00 a.m., Resident #3 was sitting in a recliner in the dining room. Resident #2 entered the dining room with clothing from his room and placed his clothing on the tables. Resident #3 asked Resident #2 what he was doing. Resident #2 responded with something inaudible on the video surveillance, while he pointed his finger at Resident #3. Resident #3 got up out of his recliner and moved toward Resident #2. Resident #2 swung at Resident #3 but missed contact. Resident #3 said to protect himself before he put his arms around Resident #2, both men grappled and both fell to the ground. The nurse who was seated at a nurses station and was not in view of the dining room heard noise that came from the dining room. Upon investigation, the nurse found both Resident #2 and Resident #3 on the ground. The nurse separated the residents. Resident #2 sustained a bruise to the posterior right arm and a linear abrasion to the mid-spine. Resident #3 sustained a non-displaced fracture to the left humerus. Both residents were placed on 15-minute checks. The investigation documented that it was determined by the medical director (MD) and a psychiatrist, that Resident #2 had a gradual dose reduction (GDR) of Zyprexa medication from 2.5 mg (milligrams), and the decision was made to stop the medication completely in December 2024. Resident #2 was reviewed in the psychopharmacological meetings and it appeared to be successful for several weeks until a few days before the altercation. The investigation documented on 4/14/25 licensed practical nurse (LPN) #2 requested Resident #2 be put back on Zyprexa 2.5 mg and the GDR be stopped. The physicians agreed, based on Resident #2's behavior tracking. The Zyprexa was re-ordered for Resident #2. According to the physician's interviews, Zyprexa 2.5 mg, an antipsychotic medication had not been able to take effect in the two days from 4/14/25 until the incident on 4/16/25. The investigation documented Resident #2 and Resident #3 had not had an altercation with each other prior to the incident. B. Resident #2 1. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #2, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included bipolar disorder (mental illness) and alcohol-induced persisting dementia. The 4/4/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He was independent with eating, toileting, personal hygiene and walking. 2. Record review The 12/17/24 interdisciplinary team (IDT) psychotherapeutic review revealed Resident #2's Zyprexa 2.5 mg was discontinued that day (12/17/24). The cognitive impairment care plan, revised 1/9/25 revealed Resident #2 had cognitive impairments, exhibited cognitive loss related to alcohol-induced persisting dementia. He had short and long term memory loss, disorganized thinking, difficulty with word finding at times and was only oriented to himself. Pertinent interventions included monitoring the resident for changes in cognitive status, notifying the physician if changes in cognitive status were noticed, providing cognitive therapy, administering medications as ordered and notifying the physician if the resident's behavior interfered with daily functioning. The 3/30/25 IDT psychotherapeutic review revealed Resident #2 was stable, with no change after the discontinuation of Zyprexa. The 4/14/25 nursing progress note, documented at 4:14 a.m., revealed Resident #2 had increased agitation, was difficult to redirect and continually paced from his room to the dining room. Another 4/14/25 nursing progress note, documented at 6:00 a.m., revealed Resident #2 again displayed increased agitation in the dining room, threw chairs and tipped a table. Another 4/14/25 nursing progress note, documented at 10:52 a.m. revealed the resident's agitation had increased The 4/14/25 behavioral progress note documented at 12:10 p.m., revealed Resident #2 voided in a trashcan in the dining room and when asked to stop he raised his voice and said no. Another 4/14/25 nursing progress note, documented at 2:10 p.m., revealed Resident #2 was more agitated than normal and he continued to pace the hallway. Another 4/15/25 nursing progress note, documented at 1:04 p.m., revealed Resident #2 was being monitored for Zyprexa use. Review of the April 2025 CPO revealed the following physician's order: Zyprexa oral tablet 2.5 mg, give at bedtime for angry outbursts, throwing chairs, and verbal aggression related to bipolar disorder, ordered 4/14/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 4/16/25 room notice notification revealed Resident #2 was moved to a private room due to increased agitation and paranoia about his belongings. At night he moved his belongings to the dining room to protect his items. The 4/16/25 nursing progress note, documented at 7:04 a.m., revealed Resident #2 was involved in a physical altercation with another resident (Resident #3) and fell to the floor. The residents were separated and placed on 15-minute checks. Resident #2 was assessed and denied any pain. The 4/18/25 nursing progress note revealed a follow-up head to toe skin assessment was completed on Resident #2 due to a fall that occurred on 4/16/25. The resident had a bruise to the back of his right arm measuring 5 centimeters (cm) by 4 cm by 0 cm. No open areas were noted. The resident denied pain. An abrasion to the resident's mid-spine measured 3 cm by 1.5 cm by 0 cm. The physician was notified. C. Resident #3 1. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included alcohol induced persisting dementia, anxiety disorder, hypertension (high blood pressure), seizures, alcohol abuse and gastro-esophageal reflux disease (GERD). The 3/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident had delusions, misconceptions or beliefs that were firmly held, contrary to reality. The resident was independent with eating, toileting and personal hygiene. 2. Resident interview Resident #3 was interviewed on 5/12/25 at 11:30 a.m. Resident #3 said he was in pain due to the incident with Resident #2 and he required surgery for his shoulder. 3. Record review The behavior care plan, initiated 9/5/24 and revised 5/5/25, revealed Resident #3 could demonstrate agitation towards other residents, often due to his delusions and potentially altered perception. The resident required assistance with his activities of daily living (ADLs) related to his alcohol-induced dementia, delusional disorder and anxiety. The care plan documented the goal was that the resident would not demonstrate aggression towards others. Interventions included the staff were to seek to divert the resident's attention elsewhere and the staff were to work to anticipate triggers. The 4/16/25 nursing progress note, documented at 6:30 a.m. revealed Resident #3 had an altercation with another resident (Resident #2) and fell to the floor. Resident #3 said I couldn't help it. He was placed on 15-minute checks, denied injury and refused a body assessment. Another 4/16/25 nursing progress note, documented at 8:14 a.m., revealed Resident #3 complained of pain in his shoulder and an Xray was ordered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Another 4/16/25 nursing progress note, documented at 4:23 p.m., revealed the Xray was positive for a fracture of Resident #3's left humeral head (shoulder). Physician's orders were received for a sling and a referral to an orthopedic surgeon was made. The 4/23/25 IDT progress note revealed Resident #3 was not the aggressor in the incident with Resident #2. -However, the facility investigation documented Resident #3 wrapped his arms around Resident #2 and both fell to the ground (see facility investigation above). The 4/23/25 pain assessment revealed Resident #3 had frequent and almost constant pain. The resident revealed his pain level was a 8 out of 10 on a pain scale of 1-10 recorded as the highest. VI. Staff interviews The psychiatrist was interviewed on 5/8/25 at 3:45 p.m. The psychiatrist said he had worked as Resident #2's psychiatrist when he lived in the community and continued to be involved with his care when he was admitted to the facility. He said because of Resident #2's alcohol use, he had dementia and needed the level of care provided in the facility. The psychiatrist said the resident continued with a small dose of Zyprexa (2.5 mg) after doing previous successful GDRs. The psychiatrist said the facility's IDT team, along with his involvement, decided to discontinue Zyprexa in December 2024. He said the Zyprexa was discontinued for a few months with success. He said in April 2025, Resident #2 started to show aggressive behavior, which was not normal for Resident #2. He said it was not just a bad day in April 2025 and it seemed his baseline was off. He said a few days before the altercation, he decided to put Resident #2 back on the Zyprexa. The psychiatrist said the Zyprexa was restarted two days before the aggressive behavior incident happened with Resident #3. The psychiatrist said two days prior to the incident was not long enough for the Zyprexa to take effect. The psychiatrist said Resident #2 was now doing well after the Zyprexa was restarted. The psychiatrist said the reason for the incident was due to Resident #2 and the GDR of Zyprexa. The psychiatrist said he had been Resident #3's psychiatrist for several years. The psychiatrist said Resident #3 was very delusional. The psychiatrist said Resident #3 was not agreeable to any medication changes. The psychiatrist said in his opinion, Resident #3 was not the reason for the altercation with Resident #2. The NHA was interviewed on 5/12/25 at 9:15 a.m. The NHA said he reviewed surveillance videos, along with resident and staff interviews for the investigation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	LPN #2 was interviewed on 5/12/25 at 11:14 a.m. She said the day of the altercation (4/16/25) between Resident #2 and Resident #3, she was in her car in the parking lot at approximately 4:30 a.m. She said she received a phone call from the nurse who separated the residents. She said she immediately came into the building and went to the floor where the altercation occurred. She said she immediately called the NHA. She said she and the NHA watched the video surveillance cameras. She said the video surveillance revealed Resident #2 attempted to punch Resident #3 but the punch did not hit Resident #3. LPN #2 said Resident #3 then grabbed Resident #2 like a wrestler would do and Resident #3 put his arms around Resident #2 and both residents fell to the ground. She said she had worked with Resident #2 for a long time and there had never been an incident like the one that occurred. She said a few days prior, the nursing staff had called the physician to restart Resident #2's Zyprexa . LPN #2 said as the Zyprexa was restarted, the staff knew to observe and let Resident #2 pace down the hallway while his medication took effect. She said that was two days prior to the incident and the medication was likely to not have taken effect yet. She said Resident #2 sustained a bruise on his back and a small skin abrasion on his arm. She said Resident #2 was placed back on Zyprexa and he was no longer agitated like he was prior to the incident. LPN #2 said the surgeon had cancelled two appointments with Resident #3 due to the surgeon's schedule and an appointment was rescheduled again. She said the resident's family member wanted an appointment to be made with a specific surgeon. The director of nursing (DON) was interviewed on 5/12/25 at 11:55 a.m. She said Resident #2 had not had any physical violence prior to the incident on 4/16/25. The DON said in the March 2025 IDT psychopharmacological meeting, Resident #2's medications and behaviors were discussed. The DON said Resident #2 was reviewed in the psychopharmacological meeting in March 2025 to determine if the resident was tolerating not being on Zyprexa. The DON said the IDT team determined in the March 2025 meeting that they would continue with the discontinuation of the Zyprexa to determine if it was a successful GDR or not. The DON said in April 2025, after monitoring Resident #2's behaviors, LPN #2 spoke to the psychiatrist about Resident #2. The DON said it was determined by the psychiatrist to put Resident #2 back on the Zyprexa 2.5 mg. The DON said that was two days before the altercation with Resident #3, which was not enough time for the medication to work. The social services director (SSD) was interviewed on 5/12/25 at 1:00 p.m. The SSD said Resident #2 had not had any physical violence before the incident on 4/16/25. The SSD said Resident #2 and Resident #3 had not had any altercations with any other residents since the incident on 4/16/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's medical director (MD) was interviewed on 5/13/25 at 10:00 a.m. via the phone. The MD said the psychopharmacological IDT meetings at the facility had a lot of clinical professionals which included himself and a psychiatrist. The MD said he had permission from the psychiatrist to speak about the situation with Resident #2. The MD said the team discussed a low dose of Zyprexa. The MD said the team discussed that bipolar disorder was not the problem for the Zyprexa, but rather Resident #2's alcohol use. He said Resident #2 was documented to be in a good mood, and slept well. He said the team used shared decision making with the insight from the psychiatrist who had worked with Resident #2 in the community prior to his admission into the facility. The MD said the discontinued Zypreza GDR happened in December 2024. The MD said for several months Resident #2 seemed to do well without the medication, until in April 2025, the facility staff noted behavioral issues, and the Zyprexa medication was added back for Resident #2. The MD said it was added back two days prior to the incident with Resident #3 on 4/16/25, which was not enough time for the medication to take effect. The MD said the medication currently worked for Resident #2. The NHA was interviewed again on 5/13/25 at 11:50 a.m. The NHA said all staff were educated about resident-to-resident abuse after the incident on 4/16/25. The NHA said the staff were educated to visually watch the residents and when a resident went to the dining room, a staff member needed to watch the residents. The NHA said Resident #2's Zyprexa took effect and his behavior was back to his baseline. The NHA said a recliner was put in Resident #3's room with his approval. The NHA said on 5/13/25 (during the survey) he purchased and installed a camera to be put into the dining room on the second floor (where the incident between Resident #2 and Resident #3 occurred). The NHA said the camera would be connected to a monitor that the nursing staff could utilize as needed to observe residents in the dining 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 - Immediate jeopardy to resident health or safety 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** 43135 Based on observations, record review and interviews, the facility failed to ensure an environment free of accident hazards for one (#1) of one resident reviewed for accidents/hazards out of 10 sample residents. Resident #1, who was at risk for elopement, required 15-minute safety checks due to inappropriate behaviors with staff and residents unrelated to his elopement risk. The staff on the fourth floor where Resident #1 resided were to observe Resident #1 and document his behaviors with the 15-minute safety checks. -However, the two certified nurse aides (CNA) and one licensed practical nurse (LPN) on duty the night of 4/11/25 failed to perform Resident #1's 15-minute safety checks per facility protocol (see nursing home administrator's (NHA) interview below). On 4/11/25 at approximately 8:14 p.m. Resident #1 rode an elevator in the facility from the fourth floor down to the first floor, walked to the front door, opened the front door, which set off an alarm, and left the facility. A staff member heard the alarm and looked out a window, however, the staff member failed to go outside and search for anyone. When the staff member did not see anyone outside, the door was relocked and the alarm was reset. At approximately 4:00 a.m. on 4/12/25 (almost eight hours after the resident left the facility through the front door, setting off the alarm) a CNA noticed Resident #1 was gone around 4:00 a.m. on 4/12/25, notified the LPN and the staff began a search for the resident. However, staff failed to notify the NHA about the missing resident until 6:13 a.m., over two hours after the staff initially noticed the resident was missing. The local police department was notified to help with the search. The police found Resident #1 at approximately 8:15 a.m., 12 hours after he left the facility. Resident #1 was sitting on a curb in a neighborhood, was confused and was unable to tell the police what had happened during the previous 12 hours. The police took Resident #1 to the local hospital where he was evaluated, determined to have no injuries and sent back to the facility. Resident #1 was immediately placed in the facility's secure unit for safety upon his return to the facility. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 5/7/25 to 5/13/25, resulting in the deficiency being cited as past noncompliance with a correction date of 4/12/25. I. Situation of serious harm (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to respond to an alarm on 4/11/25 at approximately 8:15 p.m. when Resident #1 opened the front door on the first floor and left the facility. A staff member did not investigate when he heard the front door alarm. The staff member looked out a window, and when the staff member did not see anyone, the door was relocked and the alarm was reset. Additionally, the facility failed to conduct 15-minute safety checks on Resident #1 on 4/11/25, which resulted in the facility not identifying the resident was missing until 4:00 a.m. on 4/12/25. Resident #1 was wandering in the community for approximately 12 hours before the police found him sitting on a curb in a neighborhood at approximately 8:15 a.m. on 4/12/25. The facility's failure to ensure staff conducted 15-minute safety checks on Resident #1 and responded to a door alarm appropriately created a situation for the likelihood of serious harm. II. Facility plan of correction The corrective action plan implemented by the facility in response to Resident #1's elopement on 4/11/25 was provided by the NHA on 5/5/25 at 10:00 a.m. It revealed the following: A. Immediate action to correct the deficient practice for Resident #1 On 4/12/25 at 8:00 a.m. the facility conducted an investigation into the elopement of Resident #1. The facility interviewed all staff who were on duty, which included those who were responsible for the resident's direct care. The surveillance videos were reviewed to determine when the resident left through the front door, what happened with the staff member who did not go outside to investigate when the alarm went off and what the staff on the fourth floor had done from 8:00 p.m. on 4/11/25 until 6:00 a.m. on 4/12/25. Inspection of the door alarms determined the front door alarm had functioned properly. Resident #1 was taken to a local hospital by the police for a wellness check. The physician at the hospital documented the resident had no noted injury and was cleared to return to the facility. The facility managers, the medical director of the facility, and the representative for Resident #1 determined the resident needed to be placed in a secured unit. Placement was immediate upon the resident's arrival back to the facility from the hospital on 4/12/25. B. The facility identified deficient practice 1. The facility had been having difficulty with the door alarms going off randomly due to the wind. A company came out in March 2025 and assessed and repaired all doors leading to the exterior. Staff did not search the parking lot when the door alarm sounded on 4/11/25 around 8:00 p.m. Staff assumed that the alarm sounded due to another reason (see CNA #2's interview below). 2. Resident #1 had a history of exit seeking and had a care plan for the behavior. The resident was not placed on one-to-one supervision or placed in a secure unit with increased exit seeking behavior in the last month. The resident was already on 15-minute checks for behavior. However, the documentation on the 15-minute checks did not appear accurate. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Staff did not follow block assignments (caring for residents together as a team without a specific CNA being assigned to a specific group of residents). 4. Staff had a lack of education on the elopement/missing person policy, exit seeking behavior interventions and timely reporting of a missing person to the NHA. C. Immediate actions The NHA and the director of nursing (DON) were educated on appropriate interventions for residents with exit seeking behavior by the RDCS (regional director of clinical services) on 4/12/25. The IDT (interdisciplinary team) was educated by the NHA and the DON on 4/14/25 on appropriate interventions related to exit seeking behavior. The IDT reviewed and updated, if indicated, all residents for elopement risk and community risk assessment, completed on 4/15/25. The IDT reviewed the progress notes for the last 90 days for elopement attempts for residents determined to be at risk of elopement who were not in a secured unit. The IDT reviewed and updated the care plans for residents at risk of elopement, completed 4/16/25. The IDT reviewed all residents on 15-minute checks for any reason. Seven residents were identified. Progress notes and care plans for the last 90 days were reviewed for any unidentified concerns related to the reason they were on 15-minute checks or exit seeking, and care plans were updated as indicated, completed 4/15/25. Staff were educated on who was on 15-minute checks or one-to-one supervision and a list of those identified residents was placed in the residents' electronic medical records (EMR). The IDT updated the elopement binder, completed on 4/13/24 with a list of all residents at risk for elopement, their face sheets and a photo, if allowed. The binder is located at the front desk and lists are located in the communications tab in the EMRs. All facility doors were assessed and tested by the NHA on 4/12/25 for proper alarm function. On 4/12/25 the NHA added a camera and an extra noise chime to the first floor front door. On 4/12/25 staff on all shifts received education from the DON/designee on the process a missing person/elopement, timely notification of the nurse on call or NHA, process for 15-minute checks, door alarm response process, elopement and exit seeking behaviors and interventions and specific block assignments. Any staff, not on duty or on leave, will receive education on their next scheduled workday. Agency staff will be educated before the start of their shift. On 4/14/25 the regional director of maintenance assessed and tested all doors leading to the exterior for proper function and proper alarming. On 4/15/25 the staff will be educated on reporting to the NHA/DON residents who attempt to leave the facility. (continued on next page)

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	065052	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Post Acute	2121 Mesa Dr Boulder, CO 80304

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. Actions to prevent occurrence/recurrence An elopement risk assessment will be completed on admission, change of condition, and quarterly by the IDT team. Residents determined at risk by the IDT will have a care plan in place to prevent elopement. The DON or designee will audit potential new admissions for elopement risk, determine if the facility can meet the resident's needs, and ensure a care plan with appropriate interventions is in place if appropriate. New staff hires will receive education on a missing person/elopement, timely notification of the nurse on call or NHA, process for 15-minute checks, door alarm response process, elopement and exit seeking behaviors and interventions, and specific block assignments, initiated 4/12/25. The NHA or designee will ensure the elopements binder is kept up-to-date with any new resident or change in resident elopement assessment. The NHA/designee will conduct monthly elopement drills with a designated missing resident and assess for timely staff reporting and response. The drills will be documented in a summary and include staff signatures. The drills will continue for six) months and thereafter as determined by the QAPI (quality assurance and performance improvement) committee. The NHA/designee will conduct weekly facility alarm drills, setting off the door alarms to assess for timely staff reporting and response. The drills will be documented in a summary and include staff signatures. The drills will continue for three months and thereafter, as determined by the QAPI committee. The DON/designee will audit all 15-minute check logs daily for three months, and weekly thereafter until determined by the QAPI committee there is substantial compliance that the logs are complete and signed by a licensed nurse. The audit will be documented on an audit tool. The DON/designee will conduct three random spot checks daily for three months, and weekly thereafter until determined by the QAPI committee there is substantial compliance to ensure the 15-minute check tool is accurate and matches the resident location/behavior. The DON audit will be documented on an audit tool. The unit managers will audit the progress notes five times per week for documented elopement attempts. The audit will be documented on an audit tool. Starting 4/15/25, the licensed nurses will sign off each shift on the 15-minute checks to ensure they are complete. Starting 4/l6/25, the licensed nurses on duty each shift will assign each CNA a block assignment of residents for the shift. The UM (unit manager) will spot check five times per week to ensure block assignments are in place and followed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The maintenance director (MTD) will conduct daily door alarm checks for proper function for one month, and weekly thereafter or as determined by the QAPI committee. The audits will be documented on an audit tool. A QAPI Performance Improvement Project (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA (quality assessment and assurance) meeting for a minimum of three months or until the pattern of compliance is maintained. III. Facility policy and procedure The Elopements and Wandering Residents policy, undated, was provided by the NHA on 5/7/25 at 10:15 a. m. via email. It read in pertinent part, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and/or any necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response(s) to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. The designated facility staff will look for the resident. If the resident is not located in the building or on the grounds, the administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. IV. Resident #1 A. Resident status Resident #1, age 72, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included hypertension (high blood pressure), pre-diabetes, kidney disease, frontal temporal neuro cognitive disorder (a type of dementia, affecting the frontal and temporal lobes of the brain, responsible for behavior, personality, and language), gastro-esophageal reflux disease (GERD), muscle weakness and depressive episodes. The 1/29/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident did not reject care from staff. The resident was independent with eating, toileting, showering, and personal hygiene. The resident did not need any mobility devices to ambulate. The MDS assessment indicated the resident had not exhibited wandering behaviors and it was somewhat important for the resident to go outside when the weather was good. B. Resident representative's interview Resident #1's representative was interviewed on 5/7/25 at 3:27 p.m. via the phone. The representative said Resident #1 had a unique kind of dementia and required a lot of monitoring. The representative said she did not understand how the facility could not know the resident was missing for 12 hours. She said the family's biggest fear was that something could have happened to him. The representative said when the police found Resident #1, he was blocks away from the facility, sitting on a curb and he thought he was changing a tire on a truck. C. Record review Resident #1's elopement/exit seeking/wandering care plan, initiated 3/10/25 revealed the resident was at risk for elopement related to dementia and other cognitive impairment. Resident #1 had a history of attempting to exit doors by pushing on them until they opened. The goal was for Resident #1 to not wander out of the facility. Interventions included providing the resident with redirection as needed (initiated 3/10/25), placing the resident on the secure unit (initiated 4/14/25), following the facility protocol if a wandering or elopement attempt occurred (initiated 4/15/25) and placing a photo of the resident in the elopement binder (initiated 4/15/25). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 1/28/25 wander elopement risk assessment revealed Resident #1 scored a 10 which indicated he was an elopement risk. The resident also had no elopement attempts. The 4/12/25 wander elopement risk assessment, conducted after Resident #1 eloped from the facility, revealed the resident scored a 22 and was deemed an elopement risk. The 3/1/25 nursing progress note revealed Resident #1 was on 15-minute checks for inappropriate behaviors with staff and other residents. The 3/7/25 nursing progress note revealed the resident continued to be on 15-minute checks for inappropriate sexual behaviors. The 3/6/25 community safety awareness evaluation revealed Resident #1 was severely impaired to make decisions. The resident was a potential risk due to dementia, loss of direction, fall, and generalized weakness. It was not safe for the resident to leave the facility out on pass. -Review of Resident #1's 15-minute check logs from 8:00 p.m. on 4/11/25 until 1:45 a.m. on 4/12/25 revealed a CNA documented the resident was present in the facility, however, the facility's video surveillance revealed the CNA did not check on the resident during that time (see NHA interview below). -There was no documentation that 15-minute checks were completed after 1:45 a.m. on 4/12/25. On 4/12/25 the evaluation for the secured unit placement documented the resident needed a secured unit due to habitual wandering or would wander out of their environment and was unable to find their way back. It was signed by the team members required for secured placement and included the resident representative's signature. V. Staff interviews The NHA was interviewed on 5/8/25 at 10:00 a.m. The NHA said on 4/12/25, he and the DON, LPN #2 and several others from the management team came in to investigate Resident #1's elopement and determine how it happened. The NHA said he immediately checked all of the doors and their alarms. The NHA said all of the alarms were working properly, which was why he did not call the maintenance director to come in and fix anything. The NHA said he viewed the facility's surveillance cameras during his investigation and conducted staff interviews. The NHA said Resident #1 was observed going out the front door at approximately 8:14 p.m. on 4/11/25. The NHA said all staff should round on all residents every two hours for care, but the staff on the fourth floor did not round on residents as they were supposed to do on 4/11/25. The NHA said Resident #1 was to be observed every 15 minutes and have his behaviors documented. The NHA said a CNA on the fourth floor documented on the 15-minute documentation sheet that Resident #1 was observed as ordered. The NHA said the video surveillance revealed the CNA never checked on Resident #1 on 4/11/25. The NHA said one CNA from the fourth floor left the facility in her car around 2:30 a.m. on 4/12/25 and abandoned her shift. The NHA said the two CNAs and the one (continued on next page)

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