STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and staff interviews, the facility failed to ensure one (#2) of four residents reviewed for abuse out of 13 sample residents was kept free from abuse. Specifically, the facility failed to: -Protect Resident #2 from verbal abuse from Resident #3 on two separate occasions (9/1/24 and 9/16/24); -Report an allegation of verbal abuse on 9/1/24 and 9/16/24; -Thoroughly investigate an allegation of verbal abuse of Resident #2 from Resident #3; and, -Initiate and implement interventions to prevent future resident to resident verbal altercations between Resident #2 and Resident #3. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation, Reporting and Investigating policy, dated 2001, was provided by the nursing home administrator (NHA) on 10/2/24 at 11:44 a.m. The policy read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Staff conducting the investigation should as a minimum: -Review the documentation and evidence; -Review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; -Observe the alleged victim to include his interactions with staff and other residents; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interview the person(s) reporting the incident; -Interview any witnesses to the incident; -Interview the resident or resident's representative; -Interview any witnesses to the incident; -Interview staff members on all shifts who have had contact with the resident during the period of the alleged incident; -Interview the resident's roommate, family members, and visitors; -Interview other residents; and, -Review all events leading up to the alleged incident; and, document the investigation completely and thoroughly. Witness statements should be obtained in writing, signed and dated and the NHA was responsible for determining what actions were needed for the protection of the residents after any allegations of abuse. II. Allegations of verbal abuse/resident to resident altercation between Resident #2 and Resident #3 on 9/1/24 and 9/16/24. A. Allegation of verbal abuse on 9/1/24 The NHA provided the 9/1/24 investigation on 10/1/24 at 5:10 p.m. The investigation was an interview with Resident #2 and Resident #3, conducted by the social services director (SSD). The 9/1/24 interview with Resident #2 documented Resident #2 was asked if he was called derogatory names. Resident #2 said no and said he had three friends at the facility. He said he did not know if Resident #3 knew where his family placed his items but he was looking for his bags and boxes. The SSD documented Resident #2 was pleasantly confused with the questions asked but did not show any fear, concern or outward discomfort in the questions asked regarding Resident #3. Resident #2 said he felt safe. The 9/1/24 interview with Resident #3 documented Resident #3 said Resident #2 defecated on the floor and Resident #3 stepped into it. Resident #3 said Resident #2 also had been in his dresser drawers and got lost on Resident #3's side of the room. Resident #3 said he did not get mad and knew Resident #2 could get confused. Resident #3 said if he (Resident #3) became upset, he would go for a walk. He said he did not know what the nurse was talking about in reference to the allegation. Resident #3 said he did not get mad, verbally talk down to Resident #2 or show outward aggression towards him. Resident #3 said he liked his roommate and would not hurt anyone at the facility. The resident said he felt safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/1/24 interview with another resident (Resident #6) was provided by the NHA on 10/2/24 at 6:25 p.m. The interview was conducted by the SSD. Resident #6 was asked if she had heard any verbal concerns or seen any aggression with other residents on the hall. She said she did not recall anything or she would have reported it to the SSD. Resident #6 said she felt safe at the facility. -No other documentation was provided by the facility pertaining to the 9/1/24 investigation. -There was no documentation or evidence that an allegation of abuse was reported to the appropriate parties, including the State Agency. -There was no evidence of a thorough investigation to determine if the allegation of verbal abuse was substantiated or unsubstantiated. -Review of Resident #2's electronic medical record (EMR) did not identify Resident #2 was monitored for any changes in behaviors specific to the 9/1/24 incident. -Review of Resident #2's and Resident #3's EMRs or the provided documentation did not identify either resident was offered or encouraged a room change (see interviews below) as an intervention to prevent future altercations or verbal abuse towards Resident #2 from Resident #3. -Review of Resident #2's and Resident #3's comprehensive care plans did not reveal person centered interventions were put into place for either resident after the 9/1/24 verbal abuse allegation. B. Allegation of verbal abuse on 9/16/24 Resident #3's 9/16/24 behavior progress note, documented at 12:10 p.m., revealed Resident #3 had signs and symptoms of alcohol intoxication and his speech was incoherent. According to the progress note, the staff would monitor him for safety and other behaviors. The 9/16/24 behavior progress note, documented at 10:45 p.m., revealed Resident #3 had signs and symptoms of drinking such as a strong odor of alcohol, stumbling in the hall and in his room and slurred speech. According to the progress note, Resident #3 called his roommate a derogatory name again. -Review of the requested and provided documentation revealed there was no evidence an investigation was conducted after a nurse wrote in the 9/16/24 progress note that Resident #3 called Resident #2 a derogatory name. The review of Resident #2's progress notes did not identify anyone spoke to Resident #2 on 9/16/24 or after 9/16/24 to determine how he felt about the incident, if he felt safe and he any frustration or concerns with Resident #3. -Review of Resident #2's EMR did not identify Resident #2 was monitored for any changes in behaviors specific to the 9/16/24 incident or that any person centered interventions were implemented to prevent further incidents of verbal abuse from Resident #3. III. Resident #2 A. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2, age greater than 65, admitted to the facility on [DATE] and was readmitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance/mood disturbance and anxiety, Parkinson's disease without dyskinesia and major depressive disorder. The 8/9/24 minimum data set (MDS) assessment documented Resident #2 had severe cognitive deficits with a brief interview for mental status (BIMS) score of five out of 15. Resident #2 required partial to moderate assistance with his activities of daily living (ADL) and used a wheelchair for mobility. According the MDS assessment, Resident #2 did not have physical or verbal behavioral symptoms directed at others or rejections of care. B. Resident interview Resident #2 was interviewed on 10/1/24 at 2:40 p.m. Resident #2 said he liked his current roommate but his former roommate (Resident #3) would get drunk and then be mean to him. Resident #2 said he could not recall what Resident #3 would say to him but it would make him mad. Resident #2 was interviewed a second time on 10/2/24 at 12:20 p.m. Resident #2 again said he liked his current roommate and was happy his former roommate was gone. C. Record review The cognitive impairment care plan, initiated 4/25/24, directed staff to anticipate and meet Resident #2's needs promptly. The psychosocial care plan, initiated 7/18/24, identified the following interventions: allowing the resident to have control over situations as much as possible; assessing the resident for mood or behavior issues; and, determining if the resident's mood and behavior endangered the resident and intervening if necessary. The room change care plan, initiated 7/18/24, documented Resident #2 had the potential for an impaired adjustment related to room change due to his dementia. The care plan interventions, directed staff to: -Allow the resident expressions of fear and/or concerns; -Assist the resident in problem-solving methods to assure roommate compatibility; -Encourage the resident to express feelings regarding room change; and, -Monitor the resident for adjustment to his new room. Resident #2's room change care plan goal, revised on 8/20/24, was to verbalize acceptance of his new room/roommate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #2's room change care plan did not identify new interventions after 8/20/24 or after Resident #2's roommate (Resident #3) made potential verbally abusive remarks towards Resident #2 on 9/1/24 and 9/16/24. -Resident #2's progress notes did not identify monitoring of Resident #2 after an allegation of verbal abuse on 9/1/24 and 9/16/24. IV. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE] and discharged home on 9/18/24. According to the October 2024 CPO, diagnoses included alcohol dependence with alcohol-induced persisting dementia, alcohol use, unspecified with withdrawal delirium and other abnormalities of gait and mobility. The 9/18/24 MDS assessment documented Resident #3 was cognitively intact with a BIMS score of 15 out of 15. The assessment indicated Resident #3 was independent with most of his ADLs. According to the MDS assessment, Resident #3 had verbal behavioral symptoms directed towards others as examples of threatening others, screaming at others, and/or cursing at others. B. Family representative interview Resident #3's family representative was interviewed on 10/2/24 at 6:48 p.m. The family representative said Resident #3 went to the facility for rehabilitation but started drinking again at the facility. She said there was nothing more the facility could do for Resident #3 so she and Resident #3 decided to have him return home. She said she was not informed of other behaviors or concerns other than drinking at the facility. C. Record review The mood care plan, revised 4/11/24, revealed Resident #3 was at risk of emotional distress, ineffective coping skills, and poor impulse control. The interventions directed staff to: -Assess clinical issues that could cause or contribute to his mood pattern; -Encourage the resident to express his feelings/concerns; and, -Observe for signs and symptoms of depression/emotional distress and notify the physician as needed. The alcohol dependence care plan, revised 4/11/24, documented the resident was at risk for cognitive and behavioral changes. Interventions included monitoring for any signs or symptoms of alcohol withdrawal and notifying the physician if observed, monitoring the resident for signs of depression and referring to a psychiatrist and/or psychologist as indicated. -Review of Resident #3's care plan did not identify a behavior care plan addressing verbal aggression towards others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #3's care plan did not identify new interventions after he made potential verbally abusive remarks towards Resident #2 on 9/1/24 and 9/16/24. The 9/17/24 care conference note documented a care conference was held with Resident #3 and his family representative. According to the note, Resident #3 felt it would be best for him to discharge from the facility so he could step away from triggers and bad habits that negatively affected his sobriety. According to the note, the staff discussed the current concerns of Resident #3's alcohol use relapse. -The care conference note did not identify behaviors, such as potential verbal abuse of his roommate on 9/1/24 and 9/16/24, were discussed with the resident representative. V. Staff interviews A frequent facility visitor (FFV) was interviewed on 10/1/24 at 2:51 p.m. The FFV said the facility informed her that Resident #3 called Resident #2 derogatory names so the facility conducted an investigation and was going to do a room change. The NHA was interviewed on 10/1/24 at 5:10 p.m. The NHA said he was notified by the SSD on 9/1/24 of an incident between Resident #3 and Resident #2. He said a nurse reported to the SSD that Resident #3 called Resident #2 derogatory names on 9/1/24. The NHA said he started a soft file investigation. He said the SSD interviewed both of the residents and there was no indication of psychosocial distress with either resident. He said the interviews with Resident #2 and Resident #3 was the extent of the facility's investigation of the allegation. The NHA said the facility started to discussed moving Resident #3 to a different room but Resident #3 ended up discharging from the facility on 9/18/24. He said the allegation was not reported to the State Agency because neither resident expressed distress. The NHA said he was not aware of any other allegations or altercations between Resident #3 and Resident #2. He said nothing was reported to him regarding Resident #3 calling Resident #2 derogatory names again on or after 9/16/24. The SSD was interviewed on 10/2/24 at approximately 10:00 a.m. The SSD said a certified nursing assistant (CNA) informed her Resident #3 was verbally inappropriate towards Resident #2 after Resident #2 had an accident on the floor. She said Resident #3, under the influence of alcohol, may have stepped in it and responded by not saying nice things to Resident #2. The SSD said she spoke to Resident #3 on 9/1/24, after it was reported to her of the use of derogatory language towards Resident #2. The SSD said Resident #3 told her Resident #2 had defecated on the floor but he was not mad or irritated at Resident #2. The SSD said Resident #2 got confused and would go through Resident #3's drawers but Resident #3 liked Resident #2. The SSD said Resident #3 told her if he felt upset with Resident #2, he would just go for a walk. The SSD said her conversation with Resident #3 was normal and he did not state aggression towards Resident #2. The SSD said she did not recall the name of the CNA who informed her of the incident, but had asked the CNA who reported the concern to fill out a witness statement. She said she had not retrieved the statement back from the CNA but the CNA might have given it to someone else. She said it would be good to have the witness statement so it could be placed in the investigation file. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said a nurse had also told her Resident #3 called Resident #2 a derogatory name and did not feel it was okay that Resident #2 was called the name. The SSD said she did not recall the name of the nurse and the nurse did not fill out a witness statement. She said she was not sure exactly when the nurse reported the name calling to her. The SSD said she spoke to Resident #2 after she heard of the 9/1/24 incident. She said she asked him how he felt about his roommate, if he had concerns about his roommate and if his roommate was ever hurtful to him. The SSD said Resident #2 did not recall Resident #3 calling him names. She said Resident #2 was pleasantly confused. She said sometimes he had good recall and other days he did not. The SSD said Resident #2 showed no changes in behaviors or emotional distress. She said Resident #2 did not show any cause for concern. The SSD said the NHA was the abuse coordinator but she helped with the investigations. She said she did not interview any other residents regarding the incidents between Resident #2 and Resident #3 on 9/1/24 or 9/16/24. The NHA was interviewed again on 10/2/24 at 3:55 p.m. The NHA said the facility had not collected witness statements but the CNA who reported the 9/1/24 incident had been identified as CNA #1 and was going to come to the facility on [DATE] and fill out the witness statement. The NHA said the nurse also reported the derogatory name calling and was also asked to complete a witness statement but she was now stating she did not recall the incident. The NHA said, on 9/16/24, a care conference was held and discharge was discussed for Resident #3. The NHA said Resident #3 did not feel he needed anything more from the facility and did not express distress. The NHA said because Resident #3 was leaving the facility, the facility did not do anything else related to the situation. The NHA said there was no investigation after a nurse documented on 9/16/24 that Resident #2 was called a derogatory name again by Resident #3. He said the nurse was not interviewed and a witness statement was not collected. He said he had no other information other than what was in the progress note. The NHA said he would report the 9/16/24 incident this afternoon (10/2/24) and do an investigation after he was informed Resident #2 felt Resident #3 was mean and was mad about the interactions. He said it was not originally reported because there were no signs of distress. He said the facility should have done more of a follow up investigation after the incident was documented in a progress note on 9/16/24. CNA #2 was interviewed on 10/2/24 at 4:09 p.m. CNA #2 said sometimes Resident #3 was not nice and would get defensive. She said he spoke to others in a negative way. She said she heard Resident #3 call Resident #2 derogatory names and used expletive language. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #2 said she reported to the nurse her concerns of Resident #3's derogatory name calling towards Resident #2 on a couple of occasions. She said the last occasion she was aware of occurred over a month ago. She said when Resident #3 called Resident #2 names she would take Resident #2 to a safe space and tell Resident #3 that it was not okay to speak to Resident #2 in that manner. CNA #2 said the staff was trying to figure out what to do regarding the situation, and then Resident #3 left the facility. Licensed practical nurse (LPN) #1 was interviewed on 10/2/24 at 4:26 p.m. LPN #1 said she was the unit manager. She said when there was an allegation of abuse the staff met as a team and tried to determine what happened, how it affected the resident(s) and review the abuse procedure criteria. She said the facility tried to determine if the allegation caused harm and if the residents involved felt afraid. She said other residents in the facility would also be interviewed. She said the staff who may have witnessed the incident, staff who worked on the shift when the incident occurred and, if needed, staff who worked on other shifts would be interviewed. She said all interviews would be documented in a soft file. LPN #1 said the residents involved would be monitored to make sure they were doing okay after the incident. She said the monitoring would be documented in progress notes and if needed on a change of condition form. LPN #1 said calling a resident derogatory names would potentially be verbal abuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 40467 Based on interviews and record review, the facility failed to ensure one (#1) of three residents reviewed for accidents out of 13 sample residents received adequate supervision to decrease and/or prevent risk for accident hazards. Specifically the facility failed to: -Implement an effective plan of care that adequately addressed the risks posed to Resident #1 and other residents in the facility due to Resident #1's excessive alcohol consumption; -Provide adequate supervision for Resident #1, inside and outside the facility, due to the resident's excessive alcohol consumption; and, -Follow physician's orders for Resident #1 to have supervision when the resident was out of the facility. Findings include: I. Facility policy and procedure The Falls Clinical Protocol policy, dated 2001, was provided by the nursing home administrator (NHA) on 10/2/24 at 6:25 p.m. It read in pertinent part, The physician will help identify individuals with a history of falls and risk factors for falling. Staff will ask the resident and the caregiver or family about the history of falling. The staff and the physician will document in the medical record a history of one or more recent falls. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. The Alcoholic Beverage policy, dated 2001, was provided by the NHA on 10/2/24 at 6:25 p.m. It read in pertinent part, A physician's order must be received before any alcoholic beverages may be administered to a resident. Should such an order be received, the nursing supervisor receiving the order must contact the pharmacist. Should there be a medication that would interact with the alcohol, the nurse supervisor must inform the physician of the medications. Record and follow the physician's instructions. Alcoholic beverages must be paid for by the resident, his family, and/or the resident's representative. The nurse supervisor receiving the alcohol beverage must label the bottle. The label must contain the resident's name and room number. The alcoholic beverage must be treated as a medication and stored in the medication room. II. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, age greater than age 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included major depressive disorder, history of falling, atherosclerosis (plaque build up) of the native arteries of extremities with intermittent claudication (a symptom of the disease causing pain, cramping or muscle fatigue) and rest pain of the left leg, generalized muscle weakness, other abnormalities of the gait and mobility, and unspecified dementia, moderate without behavioral disturbance psychotic disturbance, mood disturbance and anxiety. The 7/26/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident used a walker for mobility. She was independent in most activities of daily living (ADLs) According to the MDS assessment, the resident had rejection of care behavioral symptoms. III. Resident interview and observation Resident #1 was interviewed on 10/2/24 at 3:15 p.m. Resident #1 said she came to the facility because she had a bad ankle but planned to return home when her ankle improved. She said she did not want to stay long term at the facility. She said she was not told on admission that she could not leave the facility independently or bring in her own alcohol. Resident #1 said the facility should have told her rights at the facility before she was admitted . She said if she knew about the rules she would not have agreed to come. Resident #1 said the facility found her with a couple of beers and a bottle of wine. She said she knew there were about 42 residents at the facility and there were 26 residents who drank or used to drink but she was the one with a bad reputation. She said some residents wanted a beer from her but she had not given them alcohol. She said the residents needed to ask for alcohol from their nurse. Resident #1 said she knew she was not supposed to leave the facility alone. She said she could go out on pass but she had to have someone come with her. She said she liked to go to thrift stores and go to the grocery store. She said she would take a cab to go shopping. She said she was supposed to have someone go with her but staff did not always have the time to go with her. Resient #1 said a lot of the residents needed help so she would visit them and see what she could do to help them. During the interview, Resident #1 did not show any signs of intoxication or being under the influence of alcohol. The resident's room was observed with the resident. There were no observations or odors of alcohol observed in her room. IV. Other resident interview Resident #7 was interviewed on 10/2/24 at 2:15 p.m. Resident #7 said a few of weeks ago Resident #1 offered her a walker bag. She said Resident #1 opened up her walker seat and a pint of whisky fell out on the floor. She said Resident #1 laughed, quickly put it back in her seat, and told Resident #7 that she did not see anything. Resident #7 said she was worried another resident would get into Resident #1's alcohol and would have to go to the hospital because they had a bad reaction with their medications and the alcohol. V. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall care plan, initiated on 4/22/24 and revised on 8/8/24, revealed Resident #1 was at risk for falls with and without injuries related to her antidepressant medication, alcohol use, antihypertensive medication, and history of falling. The resident's goal was to minimize her risk for falls to the extent possible. An intervention, dated 8/8/24, documented Resident #1 had a tendency to walk to the liquor store or call a taxi cab and bring alcohol into the facility. The intervention directed staff to keep Resident #1 within a supervised view as much as possible. According to the care plan, a request was made with the taxi cab company to speak to staff prior to picking up the resident and taking her shopping. The 5/12/24 medication administration note documented the resident's primary concern was how to get out of the facility on good terms. The resident was informed she needed to be discharged by the physician. The resident said she would speak to the physician because she needed to get some items out of storage. A 5/15/24 physician's order revealed the physician recommended Resident #1 only leave the facility with supervision and only related to housing issues. The psychosocial care plan, initiated 5/27/24, identified the resident preferred spending time away from the facility drinking alcohol. According to the care plan, the resident understood she had a PRN (as needed) order for five ounces of wine that reset every 24 hours. A physician's order dated 6/11/24 identified the resident could have a five ounce (oz) glass of wine per day every 24 hours as needed. The 6/16/24 at 5:28 a.m. nurse note identified the nurse entered the room of Resident #1 on the morning of 6/16/24. The resident was slurring her words and the room smelled of alcohol. The resident confirmed she had been drinking but said it was okay because management allowed her to have four ounces of alcohol. According to the note, there were beer cans under her bed, a brown bag with alcohol in it and multiple open and empty alcohol containers around her bed. Resident #1 refused to allow staff to clean up the area. The nurse notified the night nurse supervisor. A 6/16/24 behavior noted documented Resident #1 was walking around her room without pants or underwear on. The resident said she had been drinking. The alcohol was observed in the resident's room. The resident consented to the removal of two unopened 24 oz beers at 8.1% (percent) alcohol and three empty 11.2 oz containers of [NAME] mixed drinks, including an open but not finished [NAME] drink and a partially finished can of beer. The director of nursing (DON) and the manager on duty were notified. A late entry 6/19/24 social service note read the social services director (SSD) spoke to Resident #1 regarding consuming alcohol, sharing her alcohol, and bringing it to her room. The resident agreed to work with staff to care plan and create a safety plan. The note identified an alcohol anonymous (AA) meeting would be held in the facility starting on 6/19/24. She was encouraged to attend. According to the note, the SSD informed the resident she had the option to discharge and how to safely discharge if the resident wanted to. -Review of Resident #1's electronic medical record (EMR) and staff interviews (see interviews below) did not identify a specific safety plan or discharge plan for Resident #1. (continued on next page)

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Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no further documentation to indicate the AA meeting had occurred or whether Resident #1 had attended the meeting. A 6/19/24 health status note documented Resident #1 was sitting outside in front of the facility from 7:00 p.m. to 10:00 p.m. Resident #1 was drinking beer and sharing it with another resident. Resident #1 had several bags and boxes stacked on top of her walker. The resident denied drinking but she was very unsteady when she attempted to walk and had an odor of alcohol on her. According to the note, management was notified. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding bringing alcohol into the facility and/or sharing alcohol with other residents. The 6/17/24 at 3:53 p.m. medication administration note identified Resident #1 left the facility without signing out. The 6/17/24 at 10:17 p.m. medication administration note documented the resident returned to the facility at approximately 10:17 p.m. The 6/23/24 behavior note identified Resident #1 returned from the store with bottles of alcohol. The resident was informed that she was not allowed to bring alcohol into the facility or have it in her room. The resident said she was not aware that she could not bring in alcohol into the facility and she was going to save the alcohol for a family member. The resident allowed the staff to lock up the alcohol in the medication room. The medical director and manager on duty were notified. A 6/28/24 medication administration note documented the resident's gabapentin for neuropathy was held because the resident told the nurse she had a lot of alcohol to drink. The 6/29/24 at 5:07 a.m. nurse's note documented Resident #1's gabapentin and antidepressant were held the night of 6/28/24 due to her intoxication. According to the note, the resident said she had not been drinking but she was mumbling in speech. The nurse educated the resident that mixing her medications with alcohol could cause an adverse reaction. The resident told the nurse that she had recently drank alcohol and repeated alot three times. The resident refused for the nurse to remove any other alcohol she had in her room. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding removing the alcohol from the resident's room. The 7/3/24 physician's note documented Resident #1 was buying and bringing in alcohol in the facility. The staff was concerned about her intoxication. The resident had had falls in the facility. According to the note, the resident spoke to the physician again regarding her desire to return home. The physician wrote the resident's thought's were delusional and the resident lacked medical decision making capacity. The note identified the resident did not have a medical power of attorney and would be appropriate to assign a physician proxy (a physician decision maker for unrepresented residents). -The physician's note did not identify a plan related to the resident's alcohol use and fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/10/24 at 6:26 p.m. medication administration note read Resident #1 left the facility at 11:00 a.m. and was asked to return back to the facility for wound care and afternoon medication. According to the note, the resident still had not returned to the facility as of 6:26 p.m. -There was no further followup documentation to the medication administration note. A 7/15/24 physician's order documented Resident #1 could go out on supervised passes for shopping without medications. Another 7/15/24 physician's order documented Resident #1 could have a pass for two hours only at a time for leaving the facility for safety purposes. The 7/15/24 at 12:35 a.m. nurse's progress note documented the nurse was notified by the certified nurse aides (CNA) of a strong smell of alcohol in Resident #1's room and there was a nearly empty bottle of spiced rum by her bed, knocked over on the floor. The resident consented to the disposal of the alcohol. The physician was notified. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding bringing alcohol into the facility. The 7/24/24 medication administration note for two hour passes identified the resident was seen dropped off by the taxi near the back of the facility. The resident did not sign out and staff was unsure how long the resident was gone. The 7/24/24 medication administration note for supervision with passes identified the resident did not have staff supervision when she was out of the facility and returned by the taxi. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding not leaving the facility unsupervised. The 7/26/24 social service note read the SSD spoke with the resident reminding her not to assist other residents with cares, transfers or pushing them in their wheelchairs. The SSD informed the resident of the safety concerns. The 7/31/24 at 6:41 p.m. medication administration note documented Resident #1 went out of the facility without permission and for an undetermined amount of time. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding not leaving the facility unsupervised. The July 2024 quality assurance and performance improvement (QAPI) meeting minutes were provided by the NHA on 10/2/24 at 6:10 p.m. According to the minutes, the IDT discussed the incident trend of Resident #1 and her alcohol consumption. The minutes documented the facility was going to contact the taxi company to limit her taxi rides. The minutes read the facility was going to investigate where she was getting the alcohol from and what they could do about it (see interview below). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The QAPI minutes did not specify when the investigation was to be completed by or identify any interventions to immediately address the safety concerns related to Resident #1's alcohol consumption. A 8/8/24 physician note identified Resident #1 did not arrive at the 8/8/24 scheduled appointment. Resident #1 had requested the appointment for leg pain. The staff at the facility was contacted when the resident missed the appointment. According to the note, the resident frequently went shopping outside of the facility and purchased alcohol for herself and others. Resident #1 tried to transfer other residents. The note read the resident wanted to be helpful but did not remember she should not try to assist other residents. A 8/9/24 at 11:09 a.m. patient safety note identified Resident #1 had a glass of wine and left in a cab on pass. According to note the staff and the DON were aware and staff would monitor the resident upon her return to the facility. An 8/9/24 at 6:11 p.m. alert note documented the resident returned to the facility at 4:30 p.m. The alcohol she returned to the facility with was placed in the medication room and the NHA, the DON, and the nursing staff were made aware. Her medications were placed on hold for safety. Two medication administration notes on 8/9/24 documented Resident #1 had a pass to leave the facility for two hours every shift for safety concerns. According to the notes, the resident went out whenever she wanted and however long she wanted too. A 8/10/24 change of condition evaluation documented Resident #1 hid alcohol and drank throughout the day. The evaluation identified the resident appeared to have fallen (on 8/10/24) after drinking alcohol. According to the evaluation, the resident said she fell out of her chair. A 8/12/24 nurse note documented Resident #1 requested her order for alcohol. The resident was informed she had already had her daily limit of ordered alcohol. Resident #1 said Well I guess I will have to do a delivery. According to the note, the staff would watch for further behaviors. The 8/13/24 behavior note read Resident #1 was seen giving alcohol to another resident on 8/13/24. The resident denied having the alcohol with her after she was observed hiding the alcohol under a tree. -There was no further documentation to indicate the facility's management team followed up further with the resident regarding bringing alcohol into the facility and/or sharing alcohol with other residents. A 8/19/24 at 5:44 p.m. nurse note documented Resident #1 left the facility by herself without anyone. She went to the store and obtained bottles of beer. The alcohol was confiscated by the DON and locked in the medication room. According to the note, the nurse asked the resident why she left the facility and the resident responded because I can and walked away when the nurse was attempting to educate the resident about the importance of not leaving the facility alone. The note identified the resident had a strong odor of alcohol. The resident let go of her walker as she walked down the hallway and began to push another resident (in a wheelchair) down the hallway. The note described the resident as wobbling as she pushed the other resident down the hall. The resident was stopped by the nurse and reminded of the safety concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 10/1/24 at 5:10 p.m. The NHA said the facility had had issues with alcohol and residents sneaking out of the facility. He said Resident #1 was providing alcohol to at least one other resident who had since been discharged from the facility. He said Resident #1 would use the back door near the kitchen to exit and enter the facility. He said staff would leave the back door propped open when it should have been locked after the NHA realized the open back door was how Resident #1 was getting back into the facility. The NHA said he was not monitoring to make sure the back door was shut. He said staff had been educated and now the door was kept shut at all times. The NHA said he was not concerned about Resident #1 eloping because she would always return to the facility and she had not expressed wanting to leave the facility. The NHA said Resident #1 was no longer leaving the facility because the back door was now shut. The NHA said the backdoor can not be open from the outside. He said Resident #1 could not enter the facility without someone noticing her. He said she would have to enter the facility from the front door. He said he did not how Resident #1 continued to still get alcohol in the facility. The NHA said the investigation into Resident #1's alcohol use had been an ongoing process. He said he had been trying to find the source of her alcohol supply. He said he had spoken to staff but had not interviewed residents or residents with known alcohol use that Resident #1 spent time with. He said he would expand the investigation to interviewing residents and more staff. The NHA said Resident #1 had physician orders for wine in hopes it would deter her from seeking out additional alcohol but Resident #1 continued to consume other alcohol. He said her use was preventing her from receiving other medications because of the risk of adverse reactions with the alcohol and increased her fall risk. The NHA said Resident #1's behavior was a liability to the facility, increasing the risk of concerns that contributed to the alcohol use. He said social services and a frequent facility visitor (FFV) had met with Resident #1 to offer support and remind her of the need for supervised passes out of the facility. The NHA said Resident #1 did not have a behavior contract in place. He said he had not felt the situation had risen to that level. Licensed practical nurse (LPN) #2 was interviewed on 10/1/24 at 5:44 p.m. LPN #2 said she was concerned about how much alcohol Resident #1 brought into the facility. She said Resident #1 had fallen a couple times because she was intoxicated. LPN #2 said she had found alcohol in Resident's #1's pillow case. She said Resident #1 had snuck out of the facility several times and picked up alcohol. She said Resident #1 would contact a taxi, give them a false name and get picked up by the taxi from the facility. She said, in the last couple of weeks, Resident #1 had been more compliant with getting someone to supervise her out on pass. She said staff tried to monitor the resident during the week but thought she went out on the weekends to pick up the alcohol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 said she had concerns for Resident #1's safety related to her fall risk and her medications because of her alcohol use. She said the resident's gait was unstable when she was under the influence of alcohol and her room was frequently cluttered. LPN #2 said the resident was on several medications she should not have with alcohol but she had an order for alcohol and she would not always know if the resident had other alcoholic beverages. She said if Resident #1 stated she drank or showed signs of intoxication, she would hold the medication. LPN #2 said she was also concerned for other residents due to Resident #1's alcohol use. She said was concerned that another resident would go into her room and drink her alcohol. She said there was one resident who lived on the same hallway as Resident #1 who wandered, however she had not seen her go into Resident #1's room. LPN #2 said she was concerned she would share her alcohol with other residents. LPN #2 said she was worried about Resident #1 helping other residents, especially if she was under the influence of alcohol. She said Resident #1 would go into other residents' rooms and answer their call lights. The maintenance service director (MSD) was interviewed on 10/2/24 at approximately 9:30 a.m. The MSD said he had found bottles of alcohol hidden around the facility grounds. The social service director (SSD) was interviewed on 10/2/24 at approximately 10:00 a.m. The SSD said Resident #1 had a history of alcohol use prior to admitting to the facility. She said the staff started noticing Resident #1 bringing in alcohol near the end of May 2024 or the beginning of June 2024. She said the resident said she used alcohol for pain and felt sad and alone. She said a therapist was recommended but the resident said she felt it would be a waste of time. The SSD said an AA meeting was held at the facility about a month ago but she was not sure if she went to the meeting or not. The SSD said Resident #1 was receptive to conversations with her regarding coping skills and activities she enjoyed. The SSD said Resident #1 was starting to get better about asking staff to go out on pass with her before she left the facility. The SSD said the facility did not have a problem with alcohol until Resident #1 admitted to the facility. The SSD said staff reported that the resident had been intoxicated in the facility and bottles of alcohol had been found in her room. She said the staff had reported Resident #1 shared and provided alcohol to another resident who was discharged in mid-September 2024. She said the other resident could have also been providing the alcohol. The SSD said the alcohol in the facility had decreased since the former resident was discharged . The SSD said there were still some alcohol concerns but she had not asked Resident #1 where she was getting the alcohol. The SSD said Resident #1 had dementia and had poor decision making skills. She said she had a deep need to have time out of the facility. The SSD said she was concerned that the resident left the facility unsupervised. Registered nurse (RN) #1 was interviewed on 10/2/24 at 11:58 a.m. RN #1 said her biggest concern in the facility was alcohol. She said she had found six empty bottles of alcohol in Resident #1's room a couple of weeks ago. RN #1 said, on 9/30/24, Resident #1 was found asleep in her room with a cup of wine still in her hand. She said a couple of weeks ago a bottle of alcohol was found in her bed. (continued on next page)

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