STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 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** Based on record review and interviews, the facility failed to ensure one (#1) of three residents at risk for elopement out of three sample residents received adequate supervision and were kept free from elopement. Specifically, the facility failed to provide Resident #1 with the supervision necessary to prevent elopement. The facility's failure created a situation for the likelihood of serious harm to residents' health and safety if not immediately corrected. Resident #1 was admitted on [DATE] with a diagnosis of Wernicke's encephalopathy (a brain disorder), repeated falls, unspecified dementia, somnolence (a state of being drowsy or sleepy) and alcohol dependence. Upon admission, Resident #1 was assessed to be a high risk for elopement due to exit seeking behaviors and verbalizing the desire to leave the facility. On 4/6/25 at 3:42 p.m., Resident #1 walked out the front door of the facility unnoticed by facility staff. At 5:40 p.m., the facility staff could not find Resident #1 and began a search both inside and outside the facility. At approximately 7:30 p.m. the facility staff notified the local police department, the nursing home administrator (NHA) and the director of nursing (DON). A search of the area began, which included use of police [NAME]. Resident #1 was unable to be located during the search. At approximately 1:05 a.m. (approximately 10 hours later) Resident #1 walked into a hospital emergency room which was approximately five miles away from the facility. Resident #1 was unable to give a history to his family and the hospital staff of how he arrived at the hospital. Although no one knew how he arrived at the hospital, it was determined he crossed major intersections which included an interstate highway at night. Resident #1 sustained abrasions to his right shoulder, right eyebrow, right knee and left hand. Serious harm to Resident #1 was likely to have occurred during Resident #1's elopement on 4/6/25. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/10/25 to 6/11/25, resulting in the deficiency being cited as past noncompliance with a correction date of 4/10/25. I. Situation of serious harm (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/6/25 the facility staff noticed the resident was not in the building at approximately 5:40 p.m. The staff conducted a building and a ground search around the facility. When the staff could not locate Resident #1, notification was given to the local police department, the administration and the family at approximately 7:30 p.m. The police department utilized [NAME] in their search for the resident. According to a local hospital's medical records Resident #1 walked into the emergency room on his own on 4/7/25 at approximately 1:05 a. m. Resident #1 could not remember how he got to the emergency room, which was approximately five miles from the facility. The facility's security cameras revealed the resident exited the building on 4/6/25 at 3:42 p. m. II. Facility plan of correction The corrective action plan the facility implemented in response to Resident #1's elopement incident on 4/6/25 was provided by the NHA on 6/10/25 at 11:00 a.m. The plan documented the following: A. Immediate action The resident was seen at the local hospital and he discharged to a secured facility from the hospital. B. Identification of other residents The facility determined the deficient practice had the potential to affect all of the residents who exhibited wandering behaviors. On 4/7/25 an audit was initiated of all the residents' elopement assessments. On 4/10/25 the audit was completed by the company's clinical resource person. Residents identified as being at risk for elopement had care plans in place. Residents identified as being at risk for elopement were added to the elopement binder, which was located at the front reception desk. C. Systemic changes On 4/10/25 the elopement binder was updated and accurate based on residents' elopement assessments. On 4/7/25 education on the elopement policy and the elopement binder was initiated for all staff. The education was completed by the DON and the assistant director of nursing (ADON). The staff education was completed on 4/10/25 and was added to orientation onboarding for new hires. On 4/14/25 elopement drills were initiated to be completed quarterly by the maintenance department, the NHA and the DON. On 5/19/25 a wander prevention system was installed. The exit door alarms were updated to effectively alert staff when certain exit doors were opened. The vendors for the prevention system were contacted 4/7/25 to install a new alarm system and construction started on 5/12/25 and was completed on 5/19/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In the event a wander prevention system consent was unable to be obtained, the facility would put resident specific interventions in place. Immediate interventions may include: -15-minute checks, one-to-one supervision and moving the resident's room closer to the nursing station if appropriate. Long term interventions may include: -Offering alternate placement, behavior monitoring, medical director chart review, social services review, interdisciplinary team (IDT) and family involvement in care conferences and discussion in QA (quality assurance) meetings, and care planning. Elopement incidents were to be reviewed in QAPI (quality assurance and performance improvement) monthly if applicable. Elopement drills would be completed quarterly and added to the maintenance computer system calendar. Elopement drills would be completed by the maintenance department, the NHA and the DON. All new admissions would be reviewed and added to the clinical tracker (a computer software program to help manage clinical information). D. Monitoring The clinical tracker would be reviewed five times per week for identification of high elopement risk new admissions by the NHA/ the DON in the morning meeting. Any resident with high elopement risk would be care planned and measure(s) put in place. Social services would audit the elopement binder and would review it monthly at a minimum for accuracy and completeness and would be ongoing. The incident was reviewed in QAPI for three months or until compliance was achieved. Elopement drills would be recorded in the electronic monitoring system. III. Facility policy and procedure The Elopement policy and procedure, revised 4/10/25, was provided by the NHA on 6/10/25 at 10:39 a.m. via email. It read in pertinent part, It is the policy of this facility to provide a safe environment for all residents. The facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Wandering is defined as movement about the area without a fixed goal, and elopement is defined as slipping away secretly, running away, leaving without accompaniment or knowledge of the staff. Each resident's level of supervision required will be assessed based on observed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wandering behaviors and medical diagnoses. This information will be documented in the resident's medical record, and used in the care planning process. Residents whose assessment identified wandering behavior shall also be considered at risk for elopement. If a resident is identified at risk for elopement, the following steps will be Taken: an alarm bracelet may be placed on the resident to audibly alert staff of attempts by the resident to exit, in facilities with this capability; the resident's care plan shall address behavior using resident specific goals and/or approaches as assessed by the interdisciplinary team; current picture of the resident will be maintained in the facility; and, facility staff will ensure that all exit alarms are responded to immediately. All staff will be educated on proper identification, assessment, and treatment of residents identified as an exit seeking risk. This education will occur during orientation, and annually thereafter. IV. Resident #1 A. Resident status Resident #1, age [AGE], was admitted on [DATE] and discharged to the hospital on 4/7/25. According to the April 2025 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy, repeated falls, unspecified dementia, somnolence and alcohol dependence. He used a front wheel walker. He required supervision assistance with toileting and showering. The 4/1/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status score (BIMS) of seven out of 15. The assessment indicated he had wandered four to six days during the assessment look back period. B. Resident #1's representative's interview Resident #1's representative was interviewed on 6/10/25 at 11:48 a.m. via phone The resident's representative said Resident #1's dementia became worse recently over a short time, he was not sleeping at night and he had hallucinations that he was coordinating work crews. The representative said Resident #1 had always been good at directions and navigation which was why he was able to locate a hospital he had been in many times. The representative said they believed Resident #1 walked a trail along a canal pathway in the city (the canal trail extends 71 miles) which went under the interstate and then he knew how to get to the local hospital. The representative said by the look of his feet at the hospital he had shoes on with no socks and blisters on his feet. The representative said the facility did not call her, but texted her around 8:30 p.m. on 4/6/25 to inform her the resident was missing. The representative said she was worried and it was a miracle he was found alive. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The comprehensive care plan, initiated 3/26/25, revealed Resident #1 was an elopement/wander risk due to his dementia. The goal was that safety would be maintained through the review date and Resident #1 would not leave the facility unattended through the review date. Pertinent interventions included disguising exits, documenting wandering behavior and attempted diversional interventions, identifying patterns of wandering, intervening as appropriate and providing structured activities: toileting, going for walks inside and outside, reorientation strategies to include signs, pictures and memory boxes. The elopement wandering assessment risk, dated 3/25/25, revealed Resident #1 was a high risk for elopement. The resident made statements about wanting to leave the facility, his wandering was aimless with a potential to go outside and he had active exit seeking behaviors. The fall risk assessment, dated 3/25/25, revealed Resident #1 was disoriented, had a history of three or more falls in the last three months, had a balance problem when standing and had poor vision. The psychoactive medication assessment, dated 3/25/25, revealed the resident was to receive the medication Olanzapine (used for mental health conditions) 10 milligrams (mg). Resident #1 had persistent agitation, restlessness, persistent feelings of excessive/inappropriate guilt, had continual screaming, yelling out or crying out. Resident #1 had persistent wandering, recurrent outbursts of anger and consistently slept poorly. The nursing progress note, dated 4/5/25 at 6:35 a.m. (the day before the elopement), revealed the resident was monitored for behaviors throughout the night. He roamed in the hallways and all over the entire building with redirection impossible/ineffective. Resident #1 went into another resident's room and four staff members were unsuccessful in getting the resident to come out of the other resident's room. Resident #1 moved tables, chairs, and pulled on a call light on the wall. The facility staff called the resident's family member who spoke to the resident and encouraged him to return to his room. Resident #1 continued to throw items in his own room. The resident was stable around 4:00 a.m. The April 2025 medication treatment administration record (MAR) on 4/6/25 revealed Resident #1 was to receive Olanzapine 10 mg by mouth at bedtime on 4/6/25 for an unspecified mood disorder. He did not receive his medication from the facility on 4/6/25 because of his elopement. The nursing progress note, dated 4/7/25 (after he eloped), revealed the hospital nurse reported to the facility nurse that Resident #1 was okay and would be admitted to the hospital for confusion and an unsteady gate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA progress note, dated 4/8/25, revealed a review of the elopement incident on 4/6/25. The NHA documented Resident #1 began to exhibit wandering behaviors on 3/31/25. The family was contacted and the facility began one-to-one supervision for the resident. The family reported that the resident would pace and wander if he slept poorly. The weekend supervisor reported that on Saturday and Sunday (4/5/25 and 4/6/25), Resident #1 was wandering the halls but exhibited no exit-seeking behaviors. The resident's outside provider scheduled the resident to be transferred to a facility with a memory care unit on 4/7/25 (the day after the incident). The facility scheduled an overnight caregiver for Resident #1 until he was discharged . The resident was ambulatory and did not require any assistive devices. The NHA documented the hospital said Resident #1 walked into the emergency room a little after midnight. The NHA documented the hospital documentation indicated it was presumed the resident had not fallen and there were no signs of trauma or skin alterations. Resident #1 would discharge from the hospital to a secure placement. -However, the hospital record indicated the resident had abrasions on his right shoulder, right eyebrow, right knee and left hand. The resident had swelling to his right knee (see below). The hospital records, dated 4/7/25 at 1:05 a.m., revealed Resident #1 presented to the hospital with confusion, cold extremities and tachycardia (high heart rate) after he stumbled into the emergency room. He was not coherent and was unable to provide a clear history. He had abrasions on his right shoulder, right eyebrow, right knee and left hand. There was no clear history of trauma or a fall. Resident #1 had no acute fracture or traumatic malalignment. There was subcutaneous edema (swelling under the skin) to his right knee. V. Staff interviews The DON was interviewed on 6/10/25 at 9:30 a.m. The DON said the facility had scheduled for Resident #1 to transfer to another facility with a secured unit on Monday 4/7/25. The DON said Resident #1 eloped the day before (4/6/25). The DON said the facility management believed Resident #1 walked along a trail, without the use of his front wheel walker. The DON said Resident #1 found the emergency room of a local hospital because Resident #1's family lived in the same area as the hospital and the area was familiar. The DON said after the incident, Resident #1 went to the hospital and went to the pre-arranged secured unit. The outside provider's social worker (SW) was interviewed on 6/10/25 at 1:05 p.m. via phone The SW said he had been Resident #1's primary social worker since January 2024. The SW said the resident attended many day programs with the outside provider and had never eloped from their programs. The SW said the facility contacted the SW on 4/2/25 to inform him that Resident #1 was exit seeking. The SW said he made arrangements for Resident #1 to move to a facility with a secured unit. The SW said the secured unit facility had originally agreed to have Resident #1 transferred on Friday 4/4/25, but changed the arrangements to Monday 4/7/25. The SW said the day before Resident #1 was transferred, he eloped from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065124	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Heights Care and Rehabilitation	6000 E Iliff Ave Denver, CO 80222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was interviewed on 6/10/25 at 3:55 p.m. The NHA said prior to the 4/6/25 elopement, Resident #1 pushed open the front door on 3/31/25, but did not go outside. The NHA said due to that behavior, the facility had a one-to-one caregiver around the clock for Resident #1. The NHA said the one-to-one caregivers were assigned to Resident #1 from 3/31/25 through the morning of Friday 4/4/25. The NHA said after the three days Resident #1's behavior appeared to only escalate after bedtime. The NHA said Resident #1 did not have a caregiver on Friday 4/4/25, but due to his decreased behaviors on 4/5/25, a one-to-one caregiver was assigned from 10:30 p.m. until 6:30 a.m. The NHA said Resident #1 eloped around 3:40 p.m. on 4/6/25. The NHA said on 4/6/25 there was a receptionist at the front desk. The NHA said one of the receptionist's duties was to keep an eye on the front door for visitors entering and residents, if they went outside. The NHA said on 4/6/25, while an ambulance was bringing a resident on a stretcher into the facility through the front door, the receptionist stood up from the desk to guide the ambulance workers to the hallway they should go down. The NHA said during the short time away from the desk, Resident #1 was observed on video surveillance cameras to have walked out of the front door on 4/6/25 at 3:42 p.m. The DON and the NHA were interviewed together on 6/11/25 at 12:00 p.m. The DON and the NHA both said they believed the facility had completed a thorough investigation and put measures in place to safeguard residents from elopements. The DON and the NHA said all residents would have ongoing elopement evaluations. The DON and the NHA said to supplement the plan to correct non-compliance, a wander prevention system was installed by 5/19/25 and exit door alarms were updated to more effectively alert staff when exit doors were opened.