| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065150 | A. Building<br>B. Wing | 05/20/2025 |

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| Devonshire Care Center | 1330 Sidney Ave<br>Sterling, CO 80751 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free of accident hazards for one (#1) of three residents reviewed for accidents/hazards out of three sample residents.<br><br>Specifically, the facility failed to prevent Resident #1 from eloping on 4/27/25.<br><br>Findings include:<br><br>Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/20/25, resulting in the deficiency being cited as past noncompliance with corrective action date of 4/27/25.<br><br>I. Elopement incident on 4/27/25<br><br>Resident #1 who was at risk for elopement, required 15-minute checks related to his elopement risk. The staff on the long term care (LTC) side of the facility, where Resident #1 resided, were to observe Resient #1 and document his behaviors every 15 minutes.<br><br>On 4/27/25 at approximately 9:58 a.m. Resident #1 was taken to the church service that was held in the assisted living (AL) community by certified nurse aide (CNA) #2. The AL side of the community did not have a wanderguard system in place.<br><br>Resident #1 was left unattended and out of staff sight on the AL side of the facility, where he exited the facility via a door which led to an unsecured area of the facility grounds. Resident #1 was able to leave the facility without staff supervision.<br><br>At approximately 11:15 a.m. the nursing home administrator (NHA) and the director of nursing (DON) were notified by the staff that Resident #1 was missing. The facility began a search of the facility for Resident #1. When Resident #1 was not located inside the facility the search was extended to the facility grounds outside. Family and local police notified Resident #1 was missing.<br><br>Facility staff then began to search for Resident #1 in the surrounding neighborhood via automobiles. The DON went towards the residents previous living address which was seven blocks from the facility, Resident #1 was not located.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At approximately 12:15 p.m. Resident #1 was found three blocks (0.3 miles) away from the facility by staff in the opposite direction from his prior living address.<br><br>Resident #1 was immediately placed on a one-to-one caregiver for safety upon his return.<br><br>II. Facilities plan of correction<br><br>The corrective action plan implemented by the facility in response to Resident #1's elopement on 4/27/25 was provided by the NHA on 5/20/25 at 4:21 p.m. It revealed in pertinent part:<br><br>A. Action to correct the deficient practice for Resident #1<br><br>On 4/27/25 12:15 p.m. Resident #1 was placed on a one-to-one with staff and referrals were sent to other facilities that had locked units.<br><br>Resident #1's wanderguard was reviewed and functioning correctly on 4/27/25. All of the doors that were equipped with a wanderguard system were checked and working appropriately.<br><br>The doors that were not equipped with wanderguard were equipped with chimes on 4/27/25 and were checked every hour to ensure the chimes were functioning properly. A log was to be kept. Chime logs were to be in place until Mag Locks (specifically designed locks for doors to create a secure environment) were in place and functioning appropriately.<br><br>The elopement binder was reviewed to ensure all residents who were at risk for elopement were identified in the binder.<br><br>B. Identify others at risk<br><br>The facility reviewed other residents at risk for elopement and identified any resident with a wanderguard were at risk for the alleged deficient practice.<br><br>C. Systemic changes<br><br>The facility completed staff education on 4/27/25 in preventing resident elopement, emergency procedure for a missing resident, wandering and elopement policies and procedures via electronic education software.<br><br>The staff development coordinator (SDC)/designee educated the activities staffon residents at risk for elopement and that they should not be left unattended during an activity.<br><br>All staff were educated by the SDC on 4/27/25 on residents who were identified as an elopement riskshould not be taken to the AL side of the facility for any reason unless they were supervised and not left unattended.<br><br>D. Ongoing monitoring<br><br>The NHA/designee was to ensure the door check logs were completed three times a week for one month, then weekly for one month, or until substantial compliance was met.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Starting on 5/7/25, the main entrance door was switched to chime mode (sounds like a door bell) during business hours and when the receptionist was working. The main entrance door was switched to alarm mode at the end of reception shift.<br><br>The activities director (AD) was to monitor activities that were on the AL side of the facility to ensure the residents who were at risk for elopement were not left unsupervised/unattended.<br><br>The DON/designee would review three residents at risk for elopement weekly, then monthly for three months or until substantial compliance is met. This review included: a physician's order was in place for a wanderguard, consent was obtained and a care plan was in place.<br><br>The NHA/designee, the SDC/designee and the DON/designee would report any issues identified through the audits in the QAPI.<br><br>III. Facility policy and procedure<br><br>The Elopement and Wandering policy and procedure, dated 2/29/24, was received from the NHA on 5/20/25 at 4:32 p.m. It revealed in pertinent part, To ensure the safety and well being of all residents with potential elopement risk.<br><br>It is the goal of the facility to provide a safe environment using the least restrictive measure available in caring for residents who are exhibiting elopement behavior. The facility defines wanders as residents who move around the facility in a non-goal directed manner, but do not make efforts to leave the premises. Elopers are defined as residents who make an overt or purposeful attempt to leave the facility and do not have the ability to identify safety risks.<br><br>A Wander/Elopement assessment will be completed on all residents upon admission to the facility. The outcome is shared with the interdisciplinary team during the initial care conference, or earlier if the elopement risk is of immediate concern. The elopement risk is assessed quarterly or as needed with change of condition. Nursing staff will address initial elopement risk concerns in the baseline care plan. If the resident is identified as an elopement risk, the following will be maintained: Elopement Resident Identification form, including the current color photo, physical description of the resident, as well as approaches for an individualized plan of care will be in the elopement binder. Implementing and care planning interventions to address safety and decrease risk of elopement. A Physical Restraint Use Consent shall be obtained from the resident's responsible party if an electronic device is utilized Physician order will be required for the use of monitoring the device. The order will include checking placement of device every shift and checking function of device daily. The care plan will be updated to include that an electronic alarm system is used for resident's safety.<br><br>IV. Resident #1<br><br>A. Resident status<br><br>Resident #1, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included dementia (abnormal memory) with behavioral disturbances, Wernicke's encephalopathy (neurological deficiency caused by Vitamin B1 deficiency) and amnesia (loss of memory).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 4/26/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status score (BIMS) of six out of 15. He required supervision/touch assistance assistance with dressing, transfers, ambulation, personal hygiene and bed mobility. He required set-up assistance with meals.<br><br>The MDS identified the resident had wandering behaviors daily.<br><br>B. Observations<br><br>On 5/20/25 at 9:50 a.m. the facility tour revealed the LTC side and the AL side of the facility were open to all residents at all times. The wanderguard system was installed on all doors on the LTC side which led to the exterior of the facility. There was one wanderguard device in the hallway at the entry of the AL side of the facility from the LTC side.<br><br>The AL side of the facility did not have any wander guard devices on any of the doors leading to the exterior of the facility.<br><br>C. Record review<br><br>Review of the May 2025 CPO, revealed the following physician's orders:<br><br>Apply wanderguard to prevent the resident from going out of the facility unassisted. Monitor presence of wanderguard every shift for dementia and exit seeking, ordered on 4/22/25.<br><br>Check wanderguard every shift for placement and functioning for wandering, ordered 4/22/25.<br><br>The baseline care plan, initiated on 4/22/25, documented the resident was an elopement risk related to dementia, exit seeking and poor safety awareness. The care plan documented the goal was to minimize the risk of the resident leaving the facility. Pertinent interventions includedplacing the resident's identification form in the elopement binder, identifying patterns of wandering, distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, monitoring the residents location every 15 minutes, documenting wandering behavior and attempted diversional interventions in behavior log, wander alert and checking the placement of the resident's wanderguard every shift.<br><br>The 4/22/25 admission elopement risk assessment documented the resident was exit seeking and attempting to leave the facility immediately upon admission. Resident #1 was a high elopement risk due to dementia and poor safety awareness.<br><br>The 4/22/25 physical restraint/assistive device evaluationdocumented the resident was to use a wanderguard for elopement risk. The assessment indicated the reasons the resident neededto use a physical restraint was related to his delirium/acute confusion, exit seeking and leaving the building. This placed the resident at an increased risk for injury due to dementia and poor safety awareness. It documented Resident #1 allowed the placement of a wanderguard but was unable to remember why.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 15-minute checks documentation revealed the 15-minute checks were initiated on admission on [DATE] at 3:00 p.m. The facility completed the 15-minute checks as recommended until 4/27/25 at 10:15 a.m. On 4/27/25 at 10:00 a.m. the documentation indicated Resident #1 was in the 400 hall lobby.<br><br>-There was no documentation that indicated the 15-minute checks were completed from 10:15 a.m. to 1:00 p. m.<br><br>Review of Resident #1 progress notes in the electronic medical record (EMR) reveled:<br><br>On 4/27/25 at 10:07 a.m. a nursing note documented resident continued to wander. Resident #1 attempted to exit from the back door. Resident #1's wanderguard was on and functioning properly. Resident#1 was easily redirected however only for a minute or two. Resident #1 did not want to participate in any suggested activities.<br><br>On 4/27/25 at 2:32 p.m. a change of condition summary for providers documented Resident #1 had eloped from the facility. Resident #1 was found a few blocks from the facility with no adverse effects noted on assessment. Resident #1 was placed on a one-to-one monitoring by staff. All door alarms were routinely checked every 30 minutes by staff.<br><br>On 4/27/25 at 2:49 p.m. a nursing progress note documented Resident #1 was wandering through the hallways this shift and was attempting to leave the facility through different doors. Resident #1's wanderguard was on and functioning properly. Resident #1 was only redirectable for short periods of time. The writer indicated they asked CNA to take Resident #1 to church services in the dining room. When the writer was rounding on Resident #1, he was not found in church services. Activities aide (AA) #1 said Resident #1 left with a CNA. The facility and the facility grounds were searched and Resident #1 was not found. A CNA said she did not take Resident #1 out of church services. The writer then notified the NHA, the resident's family and the police department. Several staff members searched for Resident #1 using vehicles.<br><br>On 4/27/25 at 3:01 p.m. a nursing progress note documented the police and the resident's family were notified that Resident #1 was missing. Several staff members searched the surrounding neighborhood in vehicles. Resident #1 was found by the maintenance supervisor. Resident #1 returned to the facility with staff assistance. Nursing staff completed a skin and pain assessment. Resident #1 was placed on a one-to-one with staff for monitoring. All of the facility doors and alarms were placed on 30-minute checks.<br><br>On 4/28/25 at 10:57 a risk management note documented on 4/27/25 Resident #1 eloped from the facility. The interdisciplinary team determined the cause of elopement was due to Resident #1's cognition and exit seeking behaviors. Resident #1 was placed on a one-to one caregiver. The facility sent referrals to locked facilities for Resident #1's safety. The physician and family were aware of the situation.<br><br>V. Staff interviews<br><br>The assisted living administrator was interviewed on 5/20/25 at 3:10 p.m. She said the facility held a church service in the AL dining room on Sundays where both residents from the AL and LTC side were able to attend.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The assisted living administrator said once the residents passed the double doors in the hallway to the AL side the wanderguard system no longer worked. She said there was not a wanderguard system on the AL side of the facility.The assisted living administratorsaid the facility now has started the process of implementing wanderguards on all doors in the AL side which lead to the exterior of the building.<br><br>The NHA, the DON and the regional director of operations (RDOO) were interviewed together on 5/20/25 at 3:53 p.m.They said Resident #1 was missing for approximately 20 minutes prior to the NHA being notified of the missing resident. The staff conducted a building wide search when a resident was missing. The NHA said if the resident was not located within the building they expanded to the facility grounds and then the surrounding neighborhood.<br><br>The DON said Resident #1 was found approximately three blocks or 0.3 miles from the facility by the maintenance director.<br><br>The DON said once Resident #1 returned to the facility he was assessed by a nurse for pain and injuries. Resident #1 did not sustain any injuries.<br><br>The NHA said Resident #1 was last seen by staff at the church service being held on the AL side of the facility. The NHA said the facility held a church service that combined the AL residents with the long term care residents.<br><br>The NHA said the LTC side of the facility had a wanderguard system placed on all exit doors, however the AL side did not have wanderguard system installed on their exit doors at the time of Resident #1's elopement.<br><br>The NHA said a staff member assisted Resident #1 to the church service being held in the ALdining room. The NHA said the staff member would have had to turn off the last alarm in the hallway once they entered into the AL side of the facility.The NHA said once they were past that alarm there was not another system in place to prevent a resident from exiting the building through AL doors to the community.<br><br>The NHA said based on the investigation it was determined CNA #2 assisted Resident #1 to the AL side for church services, although the church services was ending, and left Resident #1 there. The NHA said CNA #2 returned to their assigned floor on the LTC side of the facility and beganproviding care to another resident.<br><br>The NHA said activities assistant (AA) #1 had started to assist residents out of the AL dining room as church services had ended and Resident #1 was left unsupervised in an unsecured part of the facility. The NHA said tt was determined during investigation that Resident #1 exited the AL side of the building through a door that was not equipped with a wanderguard system that led the resident to an unsecured area of the facility grounds, which allowed the resident to leave the facility.<br><br>The NHA saidit was determined by the facility and the resident's family that Resident #1 was better suited for a secure unit related to his behaviors and his elopement on 4/27/25. The NHA said the facility began sending out referrals to locked facilities for Resident #1's safety.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Qualified medication administration personnel (QMAP) #1 was interviewed on 5/20/25 at 5:30 p.m. QMAP #1 said she worked on theAL side of the community. QMAP #1 said she can turn off the wanderguard alarm in the hallway of the AL side of the building. QMAP #1 said if she found a resident from the LTC side she would turn off the alarm and assistthe resident back to the LTC side. She said she would ensure a staff member knew where the resident was found. QMAP #1 said she did not see a lot of residents from the LTC side on the AL side, except on Sundays whena church service was held in the AL dining room. QMAP #1 said AA #1 was present for the church service. QMAP #1 said she saw the staff come to get the residents after the service ended and assistedthem to the LTC side of the facility.<br><br>AA #1 was interviewed on 5/20/25 at 6:12 p.m.She said the church service started at 9:00 a.m. on Sundays in the main dining room on the AL side of the facility. AA #1 said she helped transport residents to and from the church services if they needed assistance. AA #1 said she did not invite Resident #1 to services ashe was new to thefacility and they were still getting to know him.<br><br>AA #1 said the church service was finishedwhen CNA #2 assisted Resident #2 to the dining room on the AL side. AA #1 said she told CNA #2 the servicewas ended, but CNA #2 left Resient #1 in the dining room and left the area. AA #1 said she was starting to assist residents back to the LTC side of the facility and the last time she saw Resident #1 was at approximately 9:58 a.m.AA #1 said she had saw CNA #2 and told her that services had ended and to assistResident #1 back to the LTC side.<br><br>AA #1 said when she returned to the AL dining room,Resident #1 was not there.<br><br>AA #1 said she continued with her daily activities schedule with a second church service of a different denomination starting at 10:30 a.m. on the LTC side.<br><br>AA #1 said the church service was about an hour long in the facility and she kepta log of the residents who attended the services. AA #1 said she would see staff peek into activities at times when residents were on 15-minute checks.<br><br>AA #1 said she was not aware Resident#1 was missing till the middle of the second church service that had started at 10:30 a.m.<br><br>AA #1 said she assisted in the search for Resident #1. at approximately 11:45 a.m. once she finished the second church service and assisted residents back to their room.<br><br>CNA #2 was interviewed on 5/20/25 at 6:28 p.m. She said she was asked by the nurse to take Resident #1 to the church services on the AL side. CNA #2 said she informed the nurse the services started at 9:00 a.m. and would be finishing soon, but the nurse still said to take Resident #1 there.<br><br>CNA #2 said she took the resident to the AL side and turned off the last wanderguard alarm in order to get the resident to the dining room. CNA #1 said the church service was still going on so she left Resident #1 there,returned to her assigned wing and assisted other resident needs.<br><br>CNA #2 said she was busy with resident cares and thought the AA #1 had assisted Resident #1 back.<br><br>CNA #2 said she was informed by another CNA that Resident #1 was missing and then she was assigned to help look for Resident #1.<br><br>(continued on next page) |

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