

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on observations, record review, and interviews, the facility failed to ensure that one (#1) of three out of six sample residents was kept safe and free from elopement.</p> <p>Resident #1 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (a chronic, progressive neurological condition) with dyskinesia (involuntary movements). A wander/elopement risk evaluation, completed upon the resident's admission on 8/31/24, revealed Resident #1 had no previous elopement attempts and was not at risk for eloping or wandering.</p> <p>Resident #1's record review revealed the following attempted and successful elopements after admission:</p> <p>On 9/4/24, a progress note revealed Resident #1 left the facility through the South Short Hall emergency exit and was verbally redirected inside.</p> <p>On 9/5/24, Resident #1 was agitated, packed his suitcase, and dragged it to the front door of the facility with his walker. The front door keypad was not armed and Resident #1 exited the facility, fell outside in the grass, and got himself up. He became aggressive when staff attempted to help him up or offered stand-by assistance. After 45 minutes, the resident agreed to sit in a wheelchair and staff transported him back inside the facility.</p> <p>On 9/10/24, Resident #1 displayed restlessness as he paced from one side of the building to the other for over an hour. The resident stated he was bored but refused activities the staff offered. Resident #1 went to the front of the facility and said he was waiting for the bus but it was unclear where he wanted to go. Resident #1 attempted to go out the front door but the keypad was armed which locked the door without the code. The resident walked toward another hallway, saw the emergency exit in the North Hall, exited the facility, and walked toward a bus parked outside the front of the building. The nursing home administrator (NHA) attempted to redirect the resident verbally but he was agitated and got on the bus. The facility called emergency medical services (EMS) for support. EMS arrived and after 20 minutes, Resident #1 agreed to get off the bus and into a wheelchair and was transported inside the facility.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Despite Resident #1's exit-seeking behaviors and successful elopements from the facility within 11 days of his admission on 9/4/24, 9/5/24, and 9/10/24, the facility failed to reassess the resident's elopement risk and implement interventions to prevent the resident from again eloping from the facility.</p> <p>On 9/11/24, Resident #1 exited the facility through the emergency exit on the South Long Hall. The door alarm on the emergency exit was not turned on and staff were informed by a resident of Resident #1's elopement. A conflicting report among staff members revealed the resident was missing for five to 30 minutes before facility staff began to search for the resident.</p> <p>Resident #1 was missing from the facility for 42 hours before he was found by the local search and rescue team and taken to the hospital where he was diagnosed with dehydration, three sunburns, and a deep, concerning stage 3 pressure injury which was not present at the time the resident eloped from the facility on 9/11/24.</p> <p>On 9/23/24, Resident #1 returned to the facility from the hospital but was hospitalized again on 10/4/24, and his pressure injury was diagnosed as a progressive stage 4. The hospital recommended surgical repair which the resident and the family declined. Resident #1 was sent to a hospice center where he passed away.</p> <p>The facility's failure to reassess Resident #1 as an elopement risk after his first three elopement attempts, failure to implement interventions to decrease Resident #1's risk of elopement, and failure to arm emergency exits properly, contributed to the resident's successful elopement attempt on 9/11/24.</p> <p>According to the NHA, the facility created an action plan and performance improvement plan to check the alarms on the emergency exit alarm at shift change, twice a day after Resident #1's elopement from the facility. She said the residents were all assessed for elopement risk and staff were provided education on the emergency exits.</p> <p>However, on 11/13/24, during the survey, the emergency exits on the South Hall Short and the South Hall Long were tested and the alarms were not armed and alarms did not sound when the exit doors were opened. The emergency exit in the North Hall was tested . Although the door was armed, staff failed to respond to the sound of the alarm.</p> <p>The facility's failure to prevent elopement, which resulted in serious harm to Resident #1, and failure to ensure a systemic, effective, and sustainable approach to prevent further elopements, created a situation of immediate jeopardy for serious harm.</p> <p>Finding include:</p> <p>I. Immediate jeopardy</p> <p>A. Situation of immediate jeopardy</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1, who was diagnosed with Parkinson's disease with dyskinesia had three successful elopements from the facility, on 9/4/24, 9/5/24, and 9/10/24 before he went missing. On 9/11/24, Resident #1 eloped from the facility when the emergency exit alarms were not activated. The lack of the door alarms functioning appropriately contributed to the facility's failure to ensure the resident's safety.</p> <p>Additionally, on 11/13/24, during the survey, the emergency exits in the South Hall Short and the South Hall Long were tested and the alarms were not armed, which caused the alarms not to sound. The emergency exit in the North Hall was tested and, although the door was armed, staff failed to respond to the sound of the alarm.</p> <p>The facility had not implemented a systemic, effective, and sustainable process to ensure the alarms on the emergency exit doors were functioning properly and that staff responded timely if an exit door alarm sounded to prevent additional resident elopements. These failures created a situation of immediate jeopardy for serious harm.</p> <p>B. Imposition of immediate jeopardy</p> <p>On 11/14/24 at 2:05 p.m., the NHA was notified of the immediate jeopardy situation created by the facility's failure to prevent Resident #1's elopement, which resulted in serious harm and the facility's failure to ensure a systemic, effective, and sustainable process to prevent further elopements.</p> <p>C. Facility plan to remove immediate jeopardy</p> <p>On 11/15/24 at 1:00 p.m., the facility submitted a plan to remove immediate jeopardy. The plan read:</p> <p>Identified concern: Resident #1 eloped the evening of 9/11/24. Upon quality assurance (QA) review of the incident, several opportunities were identified to decrease the risk of similar elopement risks. Identified the alarm at the west end of South Hall was turned off at the time of the elopement. Resident #1 had two attempts of exiting the community prior to this incident, no re-assessment was completed and no update to the care plan.</p> <p>Action plan:</p> <ul style="list-style-type: none"> -The director of nursing (DON) or designee to complete the elopement assessment review of all residents by 9/13/24; -The DON or designee to implement or update plan of care with each resident identified at risk; -The NHA or designee will review the elopement binders and ensure that all high-risk residents are placed in the binder at each nurses' station; -The staff development coordinator (SDC) or designee will initiate a full house education on 9/12/24 regarding the elopement policy and procedures to include elopement binder, ensuring all exit alarms are on and functioning, appropriate redirection and diversional activities and how to respond to an elopement; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The director of maintenance (DOM) or designee will ensure that all door alarms are functioning on 9/12/24;</p> <p>-The DOM or designee to monitor and check door alarm function twice daily for seven days;</p> <p>-The DON or designee to review all completed elopement assessments daily Monday through Friday to ensure appropriate person-centered interventions are in place and that the elopement binder is current and updated;</p> <p>-The DON or designee will review all changes of condition and notes related to increased wandering or exit seeking to ensure a new elopement assessment is completed and will update the plan of care with new person-centered interventions daily as needed; and,</p> <p>-The action plan to be reviewed at the next quality assurance and performance improvement (QAPI) meeting and revised as needed.</p> <p>The plan was updated on 11/14/24 after the door alarms were not armed and immediate jeopardy was called.</p> <p>-The NHA or designee will review the elopement binders and ensure that all high-risk residents are placed in the binder at each nurses' station (ongoing);</p> <p>-All staff re-educated in elopement policy, alarm check procedures and staff response expectations. All staff were educated on the new alarm system process which was provided by the NHA and SDC.</p> <p>-On 11/13/24, the DOM installed new emergency push bars with alarms to emergency exit doors. The push bar requires a key to arm or disarm the alarm;</p> <p>-On 11/13/24, the door alarm checks were increased to hourly by floor staff and two times a shift by the NHA or designee; and;</p> <p>-On 11/14/24, the DOM removed the keypad alarm system.</p> <p>D. Removal of the immediate jeopardy</p> <p>The immediate jeopardy situation was removed on 11/15/24 at 1:00 p.m., based on the implementation of the above plan to prevent elopements and to maintain resident safety. However, the deficient practice remained at a G level, isolated, actual harm.</p> <p>II. Facility policy</p> <p>The Elopement and Wandering policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 11/14/24 at 11:05 a.m. It read in pertinent:</p> <p>It is a goal of the facility to provide a safe environment using the least restrictive measure available in care for residents who are exhibiting elopement behavior. '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.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A wander/elopement assessment will be completed on all residents upon admission to the facility. The outcome is shared with the interdisciplinary team (IDT) during the initial care conference. The elopement risk is assessed quarterly or as needed with change of condition.</p> <p>If the resident is identified as an elopement risk, the following will be maintained:</p> <p>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; and, implementing and care planning interventions to address safety and decrease risk of elopement.</p> <p>III. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted to the facility on [DATE] and discharged to the hospital on 10/4/24. According to the October 2024 computerized physician orders (CPO), diagnoses included nontraumatic subarachnoid hemorrhage (bleeding in the brain), cognitive-communication deficit, Parkinson's disease with dyskinesia, muscle weakness, unsteadiness on feet, and lack of coordination.</p> <p>The 10/4/24 minimum data set (MDS) assessment revealed Resident #1 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. Resident #1 was documented to use a walker and did not have a physical restraint for elopement. Resident #1 was dependent on staff to put on his footwear and required maximal assistance for toileting hygiene, showering, and upper and lower body dressing.</p> <p>B. Family interview</p> <p>Resident #1's representative was interviewed on 11/14/24 at 10:49 a.m. The representative said the resident was admitted to the facility for rehabilitation for a brain bleed on 8/31/24. She said on 9/11/24 she was informed a resident wanted to look outside the emergency exit on the South Hall Long and the staff disabled the alarm so the resident was able to open the door. She said the staff failed to turn the alarm back on and Resident #1 was able to leave the facility without the staff knowing. She said she was told the resident was missing at least 15 minutes before the staff realized he was gone and began looking for him.</p> <p>The representative said Resident #1 appeared to have slipped down a hill and laid stuck in that spot for 42 hours. She said when search and rescue found the resident, he had a large pressure sore on his left buttocks that he did not have before he eloped from the facility. The representative said Resident #1 was admitted to the hospital for treatment for about 10 days. She said the resident returned to the facility on [DATE] and was no longer able to walk independently. The representative said she was frustrated that the staff turned off the alarm so no one knew exactly when the resident went missing. The representative said she informed the facility that Resident #1 had a history of leaving his assisted living facility and she was unsure what the facility implemented to prevent elopement at the facility.</p> <p>C. Record review - repeated elopement attempts - failure of the facility to respond.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A wander/elopement risk evaluation, completed on 8/31/24, revealed Resident #1 had no previous elopement attempts and was not a risk for eloping or wandering.</p> <p>On 9/4/24, a behavior note documented in Resident #1's electronic medical record (EMR) revealed the resident attempted to leave the facility through an emergency exit door at the end of the South Short Hall at 1:30 p.m. The staff were able to notify the resident's representative and the management team.</p> <p>-The facility failed to complete a wander/elopement risk evaluation and an elopement care plan was not started.</p> <p>On 9/5/24, a behavior note documented in Resident #1's EMR revealed the resident was agitated at the nurses' station which caused a significant gait imbalance and the resident was at a higher risk of falling. Resident #1 became more agitated when staff encouraged him to use his walker or his wheelchair. The director of rehabilitation (DOR) provided therapeutic encouragement and the resident agreed to use his walker and go into his room. Resident #1 gathered and packed his belongings in his suitcase. Resident #1 attempted to drag his suitcase and walker which caused him to be even more off balance. The staff attempted to stand close to the resident in case he fell which caused the resident to escalate more. The resident then attempted to drag a therapy machine backwards but the machine was unable to be moved by the resident.</p> <p>Resident #1 pushed on the front door and went outside because the keypad on the door was not armed and the door was not locked. The DOR and additional staff followed close by for his safety. Once outside, Resident #1 became unsteady on the sidewalk. He went into the grass and fell , landing on his knees. The resident got himself up and was combative with staff. Resident #1 began walking in the middle of the street and attempted to drag his walker in an unsafe manner. Staff redirected the resident to the grass for his safety.</p> <p>The DOR and the NHA provided hands-on assistance to the resident which increased the resident's aggression toward staff. Resident #1 was tired and sat in a wheelchair provided by the staff and was transported to the empty activity room.</p> <p>-The facility again failed to complete a wander/elopement risk evaluation and an elopement care plan was not started.</p> <p>On 9/6/24, a skilled nursing note revealed Resident #1 had increased agitation and exit-seeking behaviors.</p> <p>On 9/10/24, the physician documented a visit and revealed Resident #1 was seen to follow up on his recent admission, behaviors, and exit seeking. The physician recommended re-evaluating the resident's antipsychotic medications and doses and looking into an as needed (PRN) medication for his behaviors in the early afternoon. The physician documented the resident was exit-seeking in the afternoon because he was bored.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, a behavior note revealed Resident #1 was showing signs of restlessness and he paced across the facility for over an hour. One staff member engaged the resident to ensure he was not overstimulated. The speech therapist provided a friendly conversation and attempted to redirect the resident with momentary success for approximately 15 minutes. Resident #1 said he was bored and the staff offered him different activities. Resident #1 said he liked to read and the nurse encouraged the resident to pick out several books but the resident was disinterested. The NHA provided the resident with magazine options and Resident #1 picked out two magazines but placed the magazines in the basket of his walker and continued to pace.</p> <p>Resident #1 told staff he was waiting for the bus but was unable to tell anyone where he was going. Resident #1 then saw a small transport bus in front of the facility. He attempted to go out the front door but the keypad was armed and the door was locked. The resident continued walking with his walker down the hallway, observed an emergency exit at the end of the North Hall, and walked toward the door. Resident #1 was able to get outside and climbed onto the bus. The bus driver attempted to redirect the resident off the bus and said the bus was not a public transportation bus.</p> <p>Resident #1 began escalating and refused to allow staff near him. The resident was escalating. The bus driver and the NHA disengaged with the resident and EMS was called for assistance. EMS spent approximately 20 minutes encouraging Resident #1 to get off the bus. The resident began to get fatigued and agreed to sit in the wheelchair. Resident #1 returned to his room and laid down for a nap.</p> <p>-The facility failed, yet again, to complete a wander/elopement risk evaluation, and start an elopement care plan.</p> <p>On 9/11/24, a behavior note revealed the director of nursing (DON) purchased a building activity to assist the resident with not being bored in the afternoon.</p> <p>On 9/11/24, a skilled nursing note revealed Resident #1 had agitation toward staff in the afternoon.</p> <p>On 9/11/24, an investigation was started after Resident #1 eloped. According to the investigation report:</p> <p>The certified nurse aide (CNA) was assisting another resident to bed while the nurse was completing a medication pass. Resident #1 was seen at 7:03 p.m. The resident was calmly sitting at the nurses' station. The staff noticed Resident #1 was no longer at the nurses' station at 7:08 p.m. The CNA thought the resident had gone to his room until another resident said a resident with a walker left out of the emergency exit on the South Hall Long. The search for the resident began and, after 30 minutes with no success, the police were called for assistance.</p> <p>The resident was documented as being missing for 42 hours and when the resident was found, he was assessed by emergency medical services (EMS) and transported to the hospital via ambulance. The resident was stable with no broken bones but had some scratches and bruises and a possible wound on the coccyx or lower back per the family report. Resident #1 was admitted to the facility on [DATE] with no signs of exit-seeking but was documented as having two exit-seeking attempts with a noted change in behavior and cognition with one to two hours of significantly increased pacing and agitation noted by staff with redirection provided to the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>No other residents were documented as affected by the incident.</p> <p>The investigation concluded the cause for the alarm on the emergency door not alarming at the end of the South Hall Long was that staff had turned off the alarm for another resident and failed to arm the door afterward.</p> <p>On 9/12/24, an order administration note revealed Resident #1 was [NAME] (missing in action) from the facility. The facility and the grounds were searched and all staff were interviewed regarding the resident's history of exit seeking.</p> <p>A wander/elopement risk evaluation, completed on 9/12/24, revealed Resident #1 had attempted to elope from the facility and revealed the resident had one or more risk factors that indicated he was at high risk for elopement.</p> <p>Resident #1's elopement care plan, which was not initiated until 9/12/24, revealed the resident was at risk for eloping and wandering. Interventions included: the resident's current information was to stay in the elopement binder; when the resident was showing signs of agitation, staff were not to physically redirect or tell the resident he was not able to do something; monitor the resident if he went outside to ensure he was not putting item by the fence to climb over; redirect the resident by offering help, pleasant diversions, structured activities, food, conversation, television, books, and walks; provide structured activities like toileting, walking inside and outside and using reorientation strategies which included signs, pictures and memory boxes; and assess the resident for the risk of falling.</p> <p>On 9/17/24 an elopement note for Resident #1 revealed the resident went missing on 9/12/24 for 42 hours. The resident was located by the local search and rescue team and sent to the emergency room where he was admitted with a wound to his left buttocks, and scrotal area, abrasions on his shins, three sunburns, and dehydration. The investigation revealed the resident exited out of the emergency exit on the South Hall Long. The alarm on the door did not sound because the staff disabled the alarm and did not turn the alarm back on. The resident's exit-seeking behaviors were documented for two attempts when the resident was unable to be redirected when inside the facility which required the staff to provide Resident #1 with assistance and supervision outside until the resident became tired and agreed to return inside.</p> <p>D. Record review - Resident status and facility interventions on readmission.</p> <p>On 9/23/24 a nursing progress note revealed Resident #1 was admitted back to the facility at 3:04 p.m. The resident had returned to the facility with healing sunburns, abrasions on both of his shins and a large open wound that covered almost the entire area of his left buttocks and contained a black center. Resident #1 was bed and wheelchair-bound due to his pressure wound and was admitted to the secure unit due to eloping.</p> <p>-Resident #1 had a BIMS score of 11 out of 15 on 9/6/24 and a BIMS score of seven out of 15 when he returned on 9/23/24.</p> <p>A wander/elopement risk evaluation, completed on 9/24/24, revealed Resident #1 had attempted to elope the facility and had one or more risk factors that indicated he was at high risk for eloping when he was ambulatory.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's elopement care plan (see above), revised on 9/24/24, revealed new interventions were not implemented after he eloped again.</p> <p>On 9/25/24 a skilled nursing note revealed Resident #1 had pressure wounds to his sacrum and scrotal area.</p> <p>On 10/4/24 an alert note revealed Resident #1 had wet himself and the dressing on his wound at 12:40 a.m. The resident's pressure ulcer appeared significantly deeper than the previous day with an odor and a lot of light yellow and brown drainage. Resident #1 reported excessive pain at the wound site and was unable to receive additional pain medication for several hours. Resident #1 said he wanted to be sent to the emergency room for pain control and further evaluation. The nurse attempted to clean the wound with gauze sponges and normal saline but the pain was too much for Resident #1 to tolerate.</p> <p>Non-emergency transportation was arranged for the resident and he was admitted to the hospital, where his pressure sore was diagnosed as a progressive stage 4. The hospital recommended surgical repair which would leave the resident with a colostomy bag and months of healing. The resident and the family declined. Resident #1 was sent to a hospice center where he passed away.</p> <p>E. Observations of the emergency exit alarms</p> <p>On 11/13/24 at 9:15 a.m., the emergency exit on the South Hall Short and the South Hall Long were tested and the alarms were not armed which caused the alarms not to sound.</p> <p>On 11/13/24 at 9:21 a.m., the emergency exit on the North Hall was tested and, although the door was armed, staff failed to respond to the sound of the alarm.</p> <p>IV. Staff interviews</p> <p>The NHA, corporate consultant (CC) #1 and CC #2 were interviewed on 11/13/24 at 11:39 a.m. The NHA said the facility implemented a plan of correction, provided staff education, completed elopement risk evaluations on all of the residents and emergency exit alarm checks occurred twice a day at shift change by the floor staff and documented on logs.</p> <p>The NHA said she was aware the door alarms had not been armed during the observations on the morning of 11/13/24. The NHA said she spoke to the CNA who completed the checks and the CNA said the alarms beeped and indicated the alarms were on when they had been checked earlier in the day.</p> <p>The NHA said the facility planned to monitor the emergency exits once an hour by floor staff for the following 24-48 hours. The NHA said she checked the door alarms and the alarms were on at 11:30 a.m. She said Resident #1 did not have a pressure sore before he eloped from the facility and when the resident was admitted back on 9/23/24, he was admitted to the secured unit and not ambulatory.</p> <p>CC#2 said the facility did not have any current residents who were high-risk exit seekers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A person who wished to remain anonymous was interviewed on 11/14/24 at 11:30 a.m. The person said the door alarm was not on so it did not trigger when the resident exited the building. The person said the staff propped multiple doors open with rocks to make it easier to go outside to smoke or take the trash out and Resident #1 was missing almost an hour before the staff who were working realized he was missing.</p> <p>CNA #1 was interviewed on 11/14/24 at 12:15 p.m. CNA #1 said the facility installed new alarms on the emergency exits (on 11/13/24) but the floor staff checked that the keypad and key alarms worked. She said the staff entered the code to disable the alarm and then entered the code again and when it beeped it meant the alarm was activated. CNA #1 said she did not open the door first to ensure the alarm had not malfunctioned and was not sure why the staff did not check the actual alarm first.</p> <p>CNA #2 was interviewed on 11/14/24 at 12:18 p.m. CNA #2 said the facility installed new alarms on the emergency exits (on 11/13/24) but the floor staff checked that the keypad and key alarms worked. She said the staff entered the code to disable the alarm and then entered the code again and when it beeped, it meant the alarm was activated. CNA #2 said she did not open the door first to ensure the alarm had not malfunctioned and was not sure why the staff did not check the actual alarm first.</p> <p>CNA #3 was interviewed on 11/14/24 at 12:21 p.m. CNA #3 said the facility installed new alarms on the emergency exits (on 11/13/24) but the floor staff checked that the keypad and key alarms worked. She said the staff entered the code to disable the alarm and then entered the code again and when it beeped, it meant the alarm was activated. CNA #3 said she did not open the door first to ensure the alarm had not malfunctioned and was not sure why the staff did not check the actual alarm first.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 11/14/24 at 12:25 p.m. LPN #1 said she was not the staff who checked the door alarms, usually it was the CNAs but she knew how to check the alarms. LPN #1 said Resident #1 did not have the pressure sore before he eloped.</p> <p>The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 11/14/24 at 3:29 p.m.</p> <p>-The DON said the resident went missing and returned to the facility with a pressure wound.</p> <p>-The ADON said she and the DON were the wound nurses and completed the wound care according to the hospital's wound care discharge plan. The ADON said the wound care ordered by the hospital was not a good treatment plan because the hospital ordered a cream to be placed on an opened wound instead of a regimen that included some form of medihoney with gauze and bandages.</p> <p>-The DON said Resident #1 was sent back to the hospital on 10/4/24 because he experienced a lot of pain from the wound and the facility was unable to treat the wound accurately.</p> <p>A frequent visitor (FV) to the facility was interviewed on 11/14/24 at 5:10 p.m.</p> <p>-The FV said a staff member first informed her Resident #1 was missing 30 to 60 minutes before the staff realized he was gone, but the facility was not really sure how long the resident was missing initially. She said another staff member told her it was about 15 minutes before the staff realized Resident #1 was missing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The FV said the NHA told her the resident was only missing for five minutes and that the facility waited to call the police until after 11:00 p.m. She said she was not sure why the facility delayed calling the police for help. She said the residents had complained about the staff turning off the door alarms or propping the doors open all of the time since the beginning of 2024 and it was not addressed by the facility.</p> <p>The NHA was interviewed a second time on 11/15/24 at 11:33 a.m. The NHA said Resident #1 was not an elopement risk when he was first admitted to the facility and should have been assessed again after each elopement attempt. She said the resident's elopements were reviewed as behaviors and not the resident wanting to elope from the facility. She said the resident's care plan should have been updated after the first elopement attempt. She said elopement interventions needed to be updated after each incident, not just adding a revision date change. She said the facility had room for improvement in many areas and that was why the plan of correction was started after Resident #1 eloped.</p>