STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065256	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highline Post Acute	6060 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interviews and record review, the facility failed to ensure they had activities to meet the needs and preferences of the residents for three (#6, #4 and #2) of five residents reviewed for activities out of 16 sample residents.

Specifically, the facility failed to meet the socialization and activity needs for Residents #6, #4 and #2.

Findings include:

I. Facility policy and procedure

The Activity Assessment policy, revised October 2009, was received from the nursing home administrator (NHA) on 2/28/25. It documented in pertinent part, In order to promote the physical, mental and psychosocial well-being of residents, an activity assessment is conducted and maintained for each resident. The activities assessment is used to develop an individual care plan that will allow the resident to participate in his/her choice and interest. The completed activity assessment is part of the resident's medical record and should be updated as necessary, but at least annually.

II. Activity calendars

The January 2025 activity calendar included the same activities each week. The only activity on Sundays were activities open for shopping. The only activities on Saturdays included news with coffee plus movie time. There were no animal related activities or outings on the calendar.

The February 2025 activities calendar included the same activities each week. The only activities offered on Sundays were activities open for shopping. The only activities on Saturdays included news with coffee and movie time. Bingo was offered on 11 out of 28 possible days as an activity.

III. Resident #6

A. Resident status

Resident #6, age [AGE], was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included atherosclerotic heart disease (plaque buildup in arteries), chronic obstructive pulmonary disease (group of lung diseases that block airflow) and bipolar disorder.

(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 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The 12/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required supervision with toileting, bathing and walking.

The assessment documented the resident's activity preferences included reading books and newspapers, listening to music, being around animals, keeping up with the news, doing activities with groups of other people and going outside when the weather was good.

B. Resident interview

Resident #6 was interviewed on 2/26/26 at 4:00 p.m. Resident #6 said she had lived at the facility for over five years. She said in the past year or year and a half, there had not been nearly as many activities compared to prior. She said the facility did bingo quite a bit but they did not do activities that they used to do that she enjoyed. She said some of the activities she used to enjoy that were no longer offered included jewelry making, art and music. She said in the past year or two years there had not been any outings outside of the facility. She said the residents used to go on outings to do shopping, and go see museums and shows. She said she really enjoyed the outings. She said she spent more time in her room now that there were not as many activities. She said she colored a lot by herself in her room and the facility provided supplies for that. She said staff handed out an activity calendar for each month but did not personally invite her to participate in activities.

C. Record review

The activity assessment for Resident #6, completed on 12/17/23, documented that Resident #6 enjoyed 1960's folk music, reading, being around animals, keeping up with the news, going out for fresh air and gardening.

-The assessment had not been updated in one year and two months.

The activities care plan, initiated on 7/18/2020 and revised on 1/11/25, documented that Resident #6 enjoyed folk music from the 1960's, being around animals, keeping up with the news, going out for fresh air and gardening. Interventions included encouraging Resident #6 to participate in activities of choice, offering materials and supplies so she could maintain independent activities, staff was to personally invite and escort her to activities, providing a monthly activity calendar and providing a daily sheet with activities.

-However, Resident #6 said staff did not invite her to activities.

-There was no documentation of the resident enjoying independent activities in her activity assessment.

IV. Resident #4

A. Resident status

Resident #4, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure, chronic kidney disease and type 2 diabetes mellitus.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/16/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required supervision or set up help with his activities of daily living (ADL) and utilized a walker for mobility in the facility. B. Resident interview Resident #4 was interviewed 2/24/25 at 3:41 p.m. Resident #4 said the facility had a bus to take residents on outings but he did not know why there had not been outings for the residents to attend. Resident #4 said activities used to be scheduled on the weekends. He said the facility used to have games, including card games and a poker game, which he led. Resident #4 said he felt the facility's residents were not participating in activities like they used to and he enjoyed activities with more physical activity that kept him stimulated. Resident #4 said movies were shown in the dining room only at certain times because noise from the kitchen was too loud in the dining room. He said movies were usually in the smaller activity room. C. Record review Resident #4's quarterly activities assessment, dated 8/12/24, documented it was very important for him to do his favorite activities. The assessment documented the location of his activities preferences as anywhere. Resident #4's activity care plan, initiated 4/11/24, documented he was currently interested in watching television (TV), watching sports channels, attending spiritual activities on Sunday, weekly catholic visits, socializing with peers and attending the weekly book club. Pertinent interventions, initiated 4/11/24, included that activities staff would provide Resident #4 with a monthly activities calendar and daily activity sheets and activities staff would socialize with Resident #4 when inviting him to group activities. -Resident #4's activity assessment and care plan did not include his preferences for card games or facility outings. V. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included type 2 diabetes mellitus, dementia, spinal stenosis (narrowing of the spinal cord canal) and dependence on a wheelchair. The 11/30/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. She required maximum assistance with bathing and moderate assistance with dressing, set up assistance with eating, and was independent with her motorized scooter. The assessment documented it was very important for her to do her favorite activities. B. Resident interview (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 was interviewed on 2/26/25 at 4:00 p.m. Resident #2 said she would like more activities on the weekends. C. Record review Resident #2's most recent activity assessment was completed on 11/28/23, upon a re-admission to the facility. The assessment documented it was important to the resident to do her favorite activities and do things with groups of people. The assessment documented she enjoyed independent and group activities, enjoyed bingo, socials and happy hours, crafts and more. She previously enjoyed gardening, cooking and going to the mall. Resident #2's care plan, revised 5/19/22, documented she enjoyed both independent and group activities. She enjoyed bingo, socials and happy hours, crafts and more. Pertinent interventions, revised 2/28/23, included that Resident #2 declined group activities because she preferred to engage in independent leisure activities or was uninterested in the group activities being offered. VI. Staff interviews The NHA and the activities consultant (AC) were interviewed together on 2/27/25 at 9:00 a.m. The NHA said activities assessments could be done on change of condition. The AC said there was an initial activities assessment done upon admission and annually and he would expect a quarterly participation activities assessment for the residents. The AC said the purpose of the quarterly assessment was to gauge the participation and make any changes or accommodations needed moving forward. The NHA said he was not aware that the movies scheduled on the weekends were not enough for the residents. He said the activities and outings were open to all residents. The NHA said activities staff typically went door to door to encourage residents to attend the activities. The AC said some residents were able to follow the monthly calendar but some residents needed a reminder about an activity. The AC said it was best practice to follow an all hands on deck approach to activities in the facility. He recommended always putting verbiage in a resident's care plan if a resident needed notification of activities specifically. The NHA was interviewed again on 2/27/25 at 10:00 a.m. The NHA said the outings activity calendar was not given out to all the residents. The NHA said activities staff could drive the facility bus and therapy staff joined the outing. The NHA said the calendar for outings was posted by the therapy department (located at the back of the facility) and it had previously been posted by the activities department (located at the front of the facility),but he said the outings calendar had not been posted this week (during the survey). The NHA said the monthly activities calendar and outings calendar were two separate calendars, but he said in December 2024 there was an outing scheduled on the monthly calendar to go see Christmas lights. The NHA said the therapy staff had also invited residents to attend an activity they hosted or outing but the facility was limited to how many people could join the outings or cooking classes. The NHA said the facility had not had many complaints about activities until the February 2025 resident council meeting. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities assistant (AA) was interviewed on 2/27/25 at 10:00 a.m. The AA said in addition to the monthly calendar, the activities department passed out a daily sheet that included the activities scheduled for the current day. She said the daily sheet also included trivia. The AA said the activities staff knocked on resident's doors to remind them an activity was taking place. The AA said there were two activities staff members scheduled each day.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that one (#1) of eight residents out of 16 sample residents remained as free from accidents as possible. Resident #1, severely cognitively impaired and with a history of elopement on 6/8/24 and frequent exit-seeking behaviors in January 2025 and February 2025, left the facility without staff knowledge on 2/5/25 between 9:30 p.m. and 10:30 p.m. He was not located until approximately 8:00 a.m. the next day. The facility's failures in responding to his elopements created a reasonable expectation, absent immediate correction, that an adverse outcome resulting in serious harm, impairment, or death would occur. Record review revealed that on 6/8/24, Resident #1 eloped from the facility and was found across the street later that day. On 6/11/24, the resident was evaluated as being at risk for future elopement. His care plan was updated the same day with interventions that read, in part, to allow the resident to wander in safe areas, to encourage attendance and participation in activities, to attempt to refocus when exhibiting behavior, and for staff to complete the elopement risk evaluation (assessment) per facility policy. -The update did not note that the resident had eloped 6/8/24, did not identify specific concerns/behaviors that might precipitate an elopement or provide individualized interventions to minimize his risk factors (independence with ambulation, his verbalized desire to go home, and his attempts to open doors), identified on the elopement assessment 6/11/24. Further, there was no plan to increase his level of supervision. Record review revealed that on 2/5/25, Resident #1 eloped from the facility a second time. He was last seen at approximately 9:30 p.m. in the building and was noted as missing by a certified nurse aide (CNA) at approximately 10:30 p.m. The time of elopement was uncertain. On 2/6/25 at approximately 8:00 a.m., facility staff located Resident #1 approximately one mile from the facility, outside an establishment with his wheelchair, wearing a coat, pants, and shoes. His vital signs were stable, but he was very cold and shivering. -Record review revealed a quarterly elopement assessment completed 12/26/24 per care plan directive (see above), failed to take into account all the resident's risks from medication, diagnoses, and his prior elopement. -Record review revealed no further care plan updates or an increase in the resident's supervision level after 6/11/24, even though the resident's medication and treatment administration record from January 2025 documented that Resident #1 had exit-seeking behaviors where he was difficult to redirect 22 out of a possible 31 days. And, the medication and treatment record from February 2025 documented that Resident #1 had exit-seeking behaviors on four out of the five days leading up to his elopement on 2/5/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Record review revealed the facility's investigation of Resident #1's elopement on 2/5/25 failed to identify root causes to prevent a recurrence or consider lapses in the facility's response. Interviews revealed delays in implementing the facility's policy/protocol once it was determined that Resident #1 was missing. Further interviews revealed that despite documentation and knowledge of Resident #1's behavior on 2/5/25, staff had a conflicting understanding of Resident #1's elopement risk and the resident's exit-seeking behaviors. On 2/25/25 at 12:45 p.m., an Immediate Jeopardy was identified based on the facility failures above that created a situation of potential serious harm for Resident #1, requiring immediate corrective action. Findings include: IMMEDIATE JEOPARDY I. Immediate Jeopardy A. Findings of Immediate Jeopardy Resident #1, with a brief interview for mental status (BIMS) assessment of three out of 15 (severe cognitive impairment), was admitted on [DATE]. An elopement assessment dated [DATE] revealed that Resident #1 was not at risk for elopement. However, less than three months later, on 6/8/24, Resident #1 eloped from the facility. He was assessed on 6/11/24 as being at risk for future elopement following the incident. His care plan was updated the same day with interventions that read, in part, to allow the resident to wander in safe areas, to encourage attendance and participation in activities, to attempt to refocus when exhibiting behavior, and for staff to complete the elopement risk assessment per facility policy. -However, the update did not note that the resident had eloped 6/8/24, did not identify specific concerns/behaviors that might precipitate an elopement or provide individualized interventions to minimize his risk factors (independence with ambulation, his verbalized desire to go home, and his attempts to open doors), identified on the elopement assessment 6/11/24. Further, there was no plan to increase his level of supervision. Record review revealed an inaccurate assessment of the resident's elopement risk on 12/26/24, and no care plan updates or an increase in the resident's supervision level after 6/11/24, even though staff documented in January 2025, Resident #1 had exit-seeking behaviors where he was difficult to redirect 22 out of a possible 31 days and in February 2025, had exit-seeking behaviors on four out of the five days leading up to an elopement on 2/5/25. On 2/5/25, Resident #1 eloped from the building a second time. He was last seen at approximately 9:30 p.m. and was noted as missing by a CNA at approximately 10:30 p.m. The time of elopement was uncertain. Facility staff began looking for the resident in the building, at the neighboring nursing facility, and in the neighborhood. The director of nursing (DON), nursing home administrator (NHA), and police were not notified until 3:00 a.m. on 2/6/25, after facility staff were unable to locate the resident. On 2/6/25 at approximately 8:00 a.m., facility staff located Resident #1 approximately one mile from the facility with his wheelchair, wearing a coat, pants, and shoes. His vital signs were stable, but he was very cold and shivering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was taken back to the facility and was placed on one-to-one staff supervision for the initial 72 hours and then on 15-minute checks. Resident #1 was also monitored for exit-seeking behaviors every shift, although the behaviors remained unspecified on his care plan. On 2/24/25 (during the survey), the facility completed a COC (change of condition) assessment for Resident #1. The revised COC assessment revealed the resident's score for elopement was 32, indicating a high risk for elopement. As of 2/25/25, the facility had not identified specific behaviors/concerns or identified new interventions to address Resident #1's high risk for elopement. Interviews with staff on 2/24/25 and 2/25/25 revealed that the director of nursing (DON) was not aware of Resident #1's ongoing exit-seeking behaviors, although staff reported the resident wandered, especially in the evening and at night, pushed on doors, and talked about going outside often. The facility failures above created a situation of Immediate Jeopardy for serious harm for Resident #1 that required immediate corrective action. On 2/25/25 at 12:45 p.m., the DON, the nursing home administrator (NHA), and the nurse consultant (NC) were notified of the Immediate Jeopardy situation. B. Facility plan to remove the Immediate Jeopardy On 2/25/25 at 6:51 p.m., the NHA provided a plan to remove the Immediate Jeopardy situation. The removal plan read: The facility will reassess all residents for elopement risk and identify triggers or predictive behaviors. The IDT (interdisciplinary) team will review and update care plans for residents at risk of elopement with individual resident centered approaches/strategies. The DON or designee will educate all staff on strategies and interventions for preventing elopement. The DON or designee will educate all staff on supervision, monitoring and reporting residents who are exit seeking. The DON or designee will educate nursing staff on notifying the NHA/DON of residents who are exit seeking, behaviors/triggers to monitor and strategies/interventions. The NHA or designee will educate all staff on the missing person policy, including timely required notifications at shift change. The education was to be completed prior to the first shift for new hires and agency staff. The DON or designee will review the behavior tracking five times per week for exit seeking behavior (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1, age less than 80, was admitted to the facility on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included dementia, depression, and type 2 diabetes. The 12/27/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The resident required partial assistance with showering and toileting. He required supervision for transfers and walking. He was independent with his wheelchair. An elopement assessment, dated 3/22/24, revealed that Resident #1 was not at risk for elopement. Resident #1 was interviewed on 2/24/25 at 10:00 a.m. He said he went outside every day. He said he loved going outside. B. First elopement - Facility failures in response 1. Elopement 6/8/24 On 6/8/24 at 2:26 p.m., a nursing note documented that around 8:00 a.m. on 6/8/24, a CNA told the nurse that Resident #1 was not in his room. The nurse checked the smoking area and other empty rooms in the building. They started searching outside the building. Resident #1 was found 30 minutes later near a daycare across the street from the facility. The NHA and the DON were notified. An elopement evaluation (assessment), completed on 6/11/24, indicated that Resident #1 was at risk for elopement based on his diagnosis of dementia, independent ambulation with a wheelchair, had wandering behaviors as part of his past, was cognitively impaired, had verbalized desire to go home or attempting to open doors, and he had a change in status or routine. A care plan for elopement risk, initiated on 6/11/24, revealed Resident #1 was at risk for elopement/exit-seeking/wandering related to dementia and intermittent delusions and that he was redirectable without agitation. Interventions included allow wandering in safe areas, approach in calm manner, assess for pain and medicate as needed, attempt to refocus, document and notify physician if behavior interferes with daily functioning, educate on facility protocol for check in/out logs, educate on potential risks and the facility protocol for leaving the facility, elopement risk assessment, encourage participation in activities of choice and encourage expression of feelings. 2. Failures in facility response The resident's care plan update did not note that he had eloped on 6/8/24, did not identify specific concerns/behaviors that might precipitate an elopement or provide individualized interventions to minimize his risk factors (independence with ambulation, his verbalized desire to go home, and his attempts to open doors), identified on the elopement assessment 6/11/24. Further, there was no plan to increase his level of supervision. C. Continuing failures after 6/8/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A quarterly elopement assessment, completed on 12/26/24, indicated that Resident #1 was independent in his wheelchair, wandered without a sense of purpose, had a diagnosis that may have impacted cognition, took one medication that could increase restlessness of agitation, had not expressed desire to leave the facility, exhibited unsafe wandering or elopement attempts but was easily redirectable. It documented that Resident #1 did not wander out of the facility but wandered into different rooms. Based on the assessment completed, resident #1 scored a 12. (The facility did not provide a scoring tool, however, lower scores indicated lower risk.) Consistent with the quarterly assessment above, Resident #1's 12/27/24 MDS assessment documented that the resident did not have wandering behaviors. -However, the 12/26/24 elopement assessment was inaccurate. Resident #1 took two medications that could increase restlessness or agitation, had two medical diagnoses that may have impacted his cognition, and had one elopement in the prior year. See also interviews below; staff reported the resident wandered, especially in the evenings and at night, and pushed on doors. 2. A review of Resident #1's medication and treatment administration record from January 2025 documented that Resident #1 had exit-seeking behaviors where he was difficult to redirect 22 out of a possible 31 days. The medication and treatment record from February 2025 documented that Resident #1 had exit-seeking behaviors on four out of the five days leading up to his elopement on 2/5/25. Record review revealed no care plan updates describing Resident #1's exit-seeking behavior and how staff might respond or a plan to increase the resident's supervision level, despite the documentation on the medication and treatment administration records for January 2025 and February 2025, and staff documentation the resident was now difficult to redirect. D. Second elopement - Failures in facility response 1. Elopement 2/5/25 On 2/6/25 at 7:27 a.m., a nursing note by LPN #3 documented that Resident #1 was missing. The note read that during the dinner time medication pass (2/5/25), Resident #1 was in his room eating and carrying his guitar. After dinner, the nurse requested the two CNAs working on his side of the hall to collect meal trays from all the rooms. At that time, the nurse did not see Resident #1 in his room and asked the CNA in charge of his daily care to look for him. -The CNA came back to the nurse later and stated that Resident #1 was on the Capital side of the building. At night, after the nurse's lunch, he started passing medication and did not see Resident #1 in his room. He asked the CNA to look for Resident #1. At the same time, the nurse went to check on another resident who was not feeling well. The CNA returned and stated that Resident #1 was still wandering in the Capital side of the building. -At 10:45 p.m., the CNAs working the graveyard shift (10:00 p.m. to 6:00 a.m.) had come in, and the new CNA in charge of Resident #1's care stated that Resident #1 was not in his room. She reported that the resident was not seen during shift change. The nurse instructed the CNA to look for the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-After a few hours of looking for him, Resident #1 was not found in the building or neighborhood. The DON was notified, and a report was given about the situation. On 2/6/25 at 7:35 a.m., a late entry nursing note by LPN #3 documented that on 2/5/25, Resident #1 went missing from the property around 10:45 p.m. All staff on shift started looking for him in each room within the facility and around the neighborhood. The DON and police were notified. Resident #1 was found on 2/6/25 between 8:00 a.m. and 9:00 a.m. All vital signs were stable, labs were done, skin was intact and cold on touch, no frostbite noted, and no signs of pain or discomfort noted. Resident #1 was placed on one one-on-one monitoring with a one-to-one sitter and 72-hour charting. On 2/6/25 at 8:40 a.m., a nursing note documented that after a long search, Resident #1 was found a few blocks away from the facility. Resident #1 appeared very cold and was shivering. He was brought back to the facility, where warm blankets awaited him. His vital signs were stable. A head-to-toe assessment revealed no sign of injury. One-on-one care was provided to Resident #1 immediately. The provider ordered lab work, a urine test, and an electrocardiogram (EKG). A review of the facility investigation of Resident #1's elopement 2/5/25 to 2/6/25 revealed the investigation was initiated on 2/6/25. It read that Resident #1 was noted missing by staff around 11:40 p.m. on 2/5/25. He was last seen by staff around 9:30 p.m. on 2/5/25. He was found by the DON and the NHA around 8:00 a.m. on 2/6/25, a few minutes away from the facility, in front of a business. He was brought back to the facility and assessed. CNA #1 was interviewed by the DON (no date or time). CNA #1 was in charge of Resident #1's care and reported she did her rounds when she came in and noted the resident was not in his room between 10:30 p. m. and 10:45 p.m. CNA #1 reported she let the nurse know at the time, and they began searching for the resident. This concluded all interviews provided in the facility's investigation. Resident #1's care plan was updated on 2/6/25 to add a one-to-one sitter, and nursing notes indicated he had the sitter from 2/6/25 until 2/9/25 at 11:30 p.m., with the nurse and staff monitoring him the rest of the night. On 2/9/25, the care plan read 15-minute checks were added and sometime later, removed from the care plan. 2. Failures in facility response a. Record review See the facility investigation above. The facility failed to conduct a comprehensive investigation to identify root causes to prevent a recurrence or consider lapses in the facility's response. See care plan additions above. As of 2/25/25 (during survey) Resident #1's care plan still lacked specific concerns/behaviors that might precipitate an elopement or provide individualized interventions to minimize his risk factors (independence with ambulation, his verbalized desire to go home, and his attempts to open doors), in addition to failing to document either of his elopements. Further, there was no evidence an elopement assessment was conducted after 2/6/25 until 2/24/25, during the survey. E. Interviews (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Staff interview Staff interviews revealed that Resident #1 was known to wander, especially in the evening and at night, pushed on doors, and talked about going outside often. a. CNA #3 was interviewed on 2/24/25 at 1:10 p.m. CNA #3 said the staff did not do shift reports at this facility. She said facility staff would leave without giving a report. She said she walked around to lay eyes on all her residents at the beginning of her shift. She said she worked with Resident #1. She said she had noticed a decline in his cognition. She said he used to be able to go outside to smoke and find his way back to his room by himself. She said that now, he wandered more aimlessly, so she made the effort to take him out to smoke when he wanted to. She said if nobody was with him or reminded him, he would wander everywhere. b. CNA #2 was interviewed on 2/24/25 at 2:55 p.m. CNA #2 said Resident #1 was very fast in his wheelchair. She said he refused care and staff had to approach him in another way, and he would usually let her do his care. She said he was very forgetful and did not call for help. She said he could walk but was not supposed to. She said he wandered around the building a lot, especially in the evenings and at night. She said he talked about going outside often. CNA #2 said she worked with Resident #1 the night he eloped. She said she was working from 2:00 p.m. to 10:00 p.m. She said he ate dinner in the dining room around 5:00 p.m. on 2/5/25. She said she brought him to the nursing station at the Cherry Creek hallway (where he lived) after dinner for a snack. She said she last saw him around 9:00 p.m. at the nursing station. She said she left at 10:00 p.m. She said that the CNA taking over for Resident #1's portion of the hall was not there yet, so she gave a report to the other CNA who was taking over the other part of the hall. She said she got a call from the DON in the middle of the night asking when was the last time she had seen Resident #1. c. LPN #1 was interviewed on 2/25/25 at 9:30 a.m. LPN #1 said Resident #1 was an elopement risk. She said he was independent with pedaling in his wheelchair and was very fast. She said his cognition had declined in the last few months, and he seemed more forgetful. She said that on every shift, she documented his exit-seeking behavior. She said his exit-seeking behavior was pedaling around the facility in his wheelchair and pushing at doors. She said that sometimes he was redirectable with a snack or activity, and other times, he would get agitated when a staff member tried to redirect him. She said the nurses used a report sheet to indicate he was on elopement precautions. She said this included documenting exit-seeking behaviors and extra monitoring. She said he was on frequent checks, meaning every 15 minutes, and she parked the cart outside his room to keep an eye on him throughout her shift. d. LPN #3 was contacted by phone. A message was left to return the call on 2/25/25 at 4:25 p.m. However, LPN #3 did not return the call. 2. Management interview (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Management (NHA, DON, and nurse consultant/NC) interviews revealed the DON was not aware of Resident #1's exit-seeking behaviors before his elopement on 2/5/25 to 2/6/25. The interviews further revealed staff conducted a search on foot and by car in the surrounding neighborhood once the resident was discovered missing. Finally, interview revealed there had been a delay, contrary to facility expectations, in contacting management about Resident #1's elopement. a. The NHA, the DON, and the NC were interviewed together on 2/24/25 at 5:00 p.m. Contrary to the treatment and medication records for January 2025 and February 2025 (see above), the DON said Resident #1 wandered in circles but was not exit-seeking. She said he did not wander into other residents' rooms. She said there was nothing about him that seemed unsafe. She said the residents became unsafe if they were heading towards the door, and he did not do that. Also, contrary to the treatment and medication records for January 2025 and February 2025 (see above), the DON said staff redirected him with snacks or activities. She said she was unable to have any meaningful conversations with Resident #1 due to his low BIMS score and cognition. The NHA said facility exit doors opened and were then alarmed if the egress bar was pushed for 15 seconds. The NHA said he went to the facility on 2/6/25 at 4:00 a.m. The NHA said the staff that worked the overnight shift on the evening of Resident #1's elopement looked for the resident in the surrounding neighborhood on foot and in their cars. The NHA said the facility was unable to determine if Resident #1 left after a family member walked out the front door or what exactly happened. The NHA said the staff members working that evening (2:00 p.m. to 10:00 p.m.) said they did not see anyone leave behind them. The NHA said staff parking was in the back of the building and staff came in the side door or through the front door, and family members parked in the street in front of the facility. The NHA said one of the facility doors had since been made inactive to enter after Resident #1's elopement. The DON said the facility cameras were not working the night Resident #1 eloped. The DON said staff checked all the side doors after his elopement and confirmed all the doors worked correctly. The DON said Resident #1 was found outside near a local business, wearing a coat, a hat, and shoes the facility thought belonged to the resident. The DON said a CNA reported that the last time she saw Resident #1, he was wearing house slippers and provided the description of Resident #1 to the police. The DON said the facility identified one CNA scheduled to relieve the day shift staff at 10:00 p.m. had arrived late to the floor (on 2/5/25), but she was not aware how late the CNA had arrived. The DON said that the facility investigation had not included checking to see if all staff came in at 10:00 p.m. as scheduled. The DON said the staff reported to her that they did their walking rounds as they came into the facility at 10:00 p. m. The DON said she came to the facility immediately upon being notified around 3:00 a.m. on 2/6/25 that Resident #1 was missing, and the NHA called 911 while he was en route to the facility and told a nurse to call the hospital. The DON then arrived at the facility, where the police met her and started their own surveillance. The DON said she got in a car with the assistant director of nursing (ADON) and tried to find the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON said if a CNA thought a resident was missing, the CNA should notify the nurse they could not find a resident. The nurse should broaden the search and look in every room, every shower room, and ask all the other staff to help search. The DON said that after searching for 20 minutes maximum, the staff should call the DON, and the DON should call the NHA. The DON said she should have been notified by midnight, at the very latest, that Resident #1 was missing. The DON said that after finding Resident #1, the resident did not articulate where he went and willingly got in the car. He said only that he left to get coffee and did not answer any other questions. The DON said she updated the medical director about the resident's elopement. She said a family member might have exited the facility unaware that Resident #1 was behind them. The DON said some of the staff would have been pulled off the floor to look for Resident #1 when they identified he was missing. The DON said the front double doors to the facility door locked at 6:00 p.m., preventing people from both leaving and entering. The DON said it was an automatic lock and was not locked manually. The DON said a person had to push on the front door for 15 seconds as it had an egress handle or enter a code on the keypad. The DON said the staff reported the door was locked at the time they exited to look for Resident #1. The DON said the staff could enter the facility by entering a code into the keypad. The DON said the facility updated Resident #1's care plan with interventions following the elopement that occurred in June 2024, and the expectation was to have a complete resident record to provide the best care for the resident. The DON said this was to ensure the facility staff could do the best work they could and provide the best care for the resident even with staff turnover. b. The NHA, the DON, and the NC were interviewed together again on 2/27/25 at 11:31 a.m. The NC said Resident #1 used his wheelchair and walked behind his wheelchair, using it like a walker. The NC said the medication administration times and care task completion records for Resident #1 were reviewed post-investigation to determine a timeline of Re[TRUNCATED]

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on record review and interviews, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under Medicare and Medicaid programs to reasonably ensure residents would be transferred from the facility to a hospital, and assured of timely admission to the hospital when transfer was medically appropriate. Specifically, the facility failed to ensure a written agreement was in effect with one local area hospital. Findings include: I. Record review A request was made to the director of nursing (DON), the nursing home administrator (NHA) and the nurse consultant (NC) on 2/25/25 at 4:00 p.m. for the facility's hospital transfer agreement. -The facility provided a statement documenting a request made to two hospitals for transfer agreements on 2/25/25. The facility was unable to provide a written agreement for the one area hospital. II. Staff interviews The NHA, the DON and the NC were interviewed together on 2/26/25 at 3:30 p.m. The NHA said they were not able to locate the transfer agreement with the local hospitals that they had in place. The NHA said when they noticed this on 2/25/25, they initiated a new hospital transfer agreement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance and performance improvement (QAPI) program committee failed to identify and address concerns related to accidents and safety of residents, which rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) Plan policy, revised April 2014, was provided by the nurse consultant (NC) on 2/27/25 at 5:00 p.m. The policy read in pertinent part, The facility shall develop, implement and maintain an ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality and resolve identified problems. The objectives of the QAPI plan are to provide a means to identify and resolve present and potential negative outcomes related to resident care and services, provide structure and process to correct identified quality and/or safety deficiencies, establish and implement plans to correct deficiencies and to monitor the effects of these action plans on the resident outcome and help departments, consultants and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services or committees. II. Cross-reference citation Cross-reference F689: The facility failed to prevent an elopement of the resident. On 2/5/25, Resident #1 eloped from the building a second time. The time of the resident's elopement was uncertain and a delay in shift change reporting may have contributed to not knowing the resident's location prior to 10:30 p.m. Facility staff began looking for the resident in the building, at the neighboring nursing facility and in the neighborhood. The director of nursing (DON) and the police were notified on 2/6/25 at 3:00 a.m. after facility staff were unable to locate the resident. On 2/6/25 at approximately 8:00 a.m., facility staff located Resident #1 approximately one mile from the facility outside a local establishment. The medication and treatment administration record from January 2025 documented that Resident #1 had exit seeking behaviors where he was difficult to redirect on 22 out of a possible 31 days. The medication and treatment record from February 2025 documented that Resident #1 had exit seeking behaviors on four out of the five days leading up to the elopement on 2/5/25. As of 2/25/25, the facility had not identified specific behaviors/concerns or identified new interventions to address Resident #1's high risk for elopement. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's failure to identify specific exit-seeking behaviors/concerns and interventions to address residents' elopement risks put residents in a situation where a serious outcome was likely to occur and created an immediate jeopardy situation. III. Staff interviews The DON, the nursing home administrator (NHA) and the NC were interviewed together on 2/27/25 at 11:31 a.m. The NHA said the facility's interdisciplinary (IDT) team met with the medical director (MD) every month to discuss issues the facility had identified. The NHA said if needed, the facility also created an ad hoc (as needed) QAPI for specific situations that might arise. The DON said the facility had daily huddles or small meetings at each nurses station to talk to the facility staff, and those changes in Resident #1's behaviors were never brought up in the huddles. The DON said Resident #1's electronic medical record (EMR) should have documented he was exit seeking and if so, then the question staff should answer was, could he be redirected. The DON said she thought Resident #1's EMR behavior documentation order was written in a way that was not clear to the facility staff. The NC said Resident #1's EMR was updated (during the survey) to clarify the language of his behavior monitoring and documentation.