

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6270 W 38th Ave Wheat Ridge, CO 80033	

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 record review and interviews, the facility failed to ensure that one (#1) of four residents out of eight sample residents received adequate supervision and facility-assisted devices to prevent elopement.</p> <p>Specifically, the facility failed to provide Resident #1 the supervision necessary to prevent elopements. These facility failures created a situation with the likelihood of serious harm to the resident's health and safety if not immediately corrected.</p> <p>Resident #1 was admitted to the facility on [DATE] with a diagnosis of bipolar disorder (major mental illness), adult failure to thrive, cocaine dependence and alcohol dependence. A wander/elopement risk evaluation was completed upon the resident's admission on 4/9/24 and revealed Resident #1 had no previous elopement attempts and was not at risk for eloping or wandering.</p> <p>However, Resident #1 had an emergency court-appointed guardian who requested the resident not leave the facility without supervision due to her mental illness and substance-seeking behaviors.</p> <p>On 1/10/25 at approximately 10:25 a.m. Resident #1 left the facility unsupervised when the receptionist buzzed someone out the front door and failed to see Resident #1 following behind the other person leaving the facility.</p> <p>After actively searching for the resident and notifying the resident's guardian about the resident's elopement, Resident #1 was located by the resident's guardian at 12:45 p.m. near a homeless shelter approximately five miles from the facility and the facility's driver picked up the resident and returned her to the facility.</p> <p>-The facility placed Resident #1 on 15-minute checks upon her return to the facility, however, this intervention proved to be ineffective as Resident #1 eloped a second time, four hours after returning to the facility.</p> <p>On 1/10/25 at 5:17 p.m., despite the facility initiating and conducting 15-minute checks on Resident #1, the resident eloped from the facility a second time when a nurse buzzed the resident out the facility door after failing to check the camera to see who was being buzzed out the door. The facility again began a search for Resident #1 and notified the police and the resident's guardian.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/11/25 at 10:15 p.m. (almost 29 hours after the resident eloped from the facility the second time) a staff member saw Resident #1 on the side of the road in a downtown area approximately five miles from the facility and notified the nursing home administrator (NHA) and the police. When the police arrived, Resident #1 was transported to the hospital, per the guardian's request.</p> <p>Findings include:</p> <p>Observations, interviews and record review confirmed the facility corrected the deficient practice prior to the onsite investigation on 2/10/25 to 2/12/25, resulting in the deficiency being cited as past noncompliance with a correction date of 1/14/25.</p> <p>I. Situation of serious harm</p> <p>The facility failed to ensure facility staff were aware of which residents were able to leave the facility without supervision and which residents needed to have supervision when leaving the facility. This resulted in a staff member buzzing Resident #1 out the front door when another person left the facility on [DATE]. The resident was located approximately five miles from the facility over two hours later.</p> <p>Following Resident #1's first elopement on 1/10/25 at 10:25 a.m., the facility failed to put effective interventions and systems in place to ensure Resident #1 was unable to elope again. This resulted in Resident #1 being buzzed out the front door a second time on 1/10/25 and being located approximately five miles from the facility almost 29 hours later.</p> <p>II. Facility plan of correction</p> <p>The corrective action plan the facility implemented in response to Resident #1's elopement incidents on 1/10/25 was provided by the NHA on 2/11/25 at 1:00 p.m. The correction plan revealed the following:</p> <p>A. Immediate action</p> <p>Resident #1 had an elopement and community safety assessment completed on 1/10/25.</p> <p>Resident #1 was found by the police on 1/11/25 and taken to the hospital per the guardian's request until a locked unit was found for Resident #1. A sister facility with a locked unit accepted the resident.</p> <p>B. Identification of others affected</p> <p>The facility determined six other residents were at risk for eloping from the facility.</p> <p>C. Systemic changes</p> <p>-On 1/13/25 all residents were educated via individual letters regarding not assisting other residents to leave the facility and the process for signing in and out when leaving the facility by the NHA or designee.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-On 1/13/25 all receptionists were educated to not leave the front desk unattended for breaks.</p> <p>-On 1/14/25 the interdisciplinary team (IDT) members reassessed all residents for elopement risk and community safety.</p> <p>-On 1/14/25 the IDT created an elopement binder, with a list of all residents at risk, their face sheets and photos, if allowed. The binder was placed at the front desk and the nurses' station.</p> <p>-On 1/14/25 staff on all shifts received education on the process for the front doors, residents at risk for eloping, notifying the nurse with concerns, location of the list of residents at risk of eloping, assisting residents to sign out and leave or redirection, elopement policy and elopement binder from the director of nursing (DON) or designee. Any staff members who were not on duty or were on leave, received education on their next scheduled work day. Agency staff were educated before the start of their shift.</p> <p>On 1/14/25 all residents' cell phone numbers were updated in the electronic medical records (EMR) by the IDT members.</p> <p>D. Preventing elopements</p> <p>The facility took the following actions to prevent elopement from reoccurring. The front desk will be staffed from 8:00 a.m. to 5:00 p.m., seven days per week and assist with helping residents sign in and out.</p> <p>Elopement risk assessments were to be completed on admission, with a change of condition, and quarterly by the IDT.</p> <p>Residents determined at risk by the IDT will have a care plan in place to prevent elopement.</p> <p>The DON will audit potential new admissions for elopement risk, determine if the facility can meet the resident's needs and ensure a care plan with appropriate interventions is in place if appropriate.</p> <p>New hires will receive education on wander, elopement and elopement binder and resident safety by the DON, the social services director (SSD) or designees.</p> <p>The NHA will ensure the elopement binders are kept up to date with any resident change in assessment or new admission.</p> <p>E. Monitoring</p> <p>The DON will track/audit all resident elopement assessments monthly to ensure they are completed on admission and quarterly.</p> <p>A quality assurance and performance improvement (QAPI) committee performance improvement plan (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAPI committed meeting for a minimum of three months, or until the pattern of compliance is maintained.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At 11:20 a.m. the NHA and the DON were notified Resident #1 had eloped. The IDT members searched known areas for the resident, which included gas stations, bus stops and downtown areas.</p> <p>At 12:00 p.m. Resident #1's guardian was notified the resident eloped. The facility's driver was asked to help search locations based on the guardian's recommendations.</p> <p>At 12:45 p.m. Resident #1's guardian located the resident near a homeless shelter approximately five miles from the facility and the facility's driver picked up the resident and returned her to the facility.</p> <p>At 1:15 p.m. Resident #1 returned to the facility, was assessed by nursing staff and placed on 15-minute checks.</p> <p>At 5:15 p.m. Resident #1 was seen in the dining room for her 15-minute check.</p> <p>At 5:17 p.m. Resident #1 was buzzed out by a nurse at the nurses' station who failed to check the camera to see who was being buzzed out the door.</p> <p>At 5:30 p.m. Resident #1 was unable to be located for her 15-minute check.</p> <p>At 5:37 p.m. the nurse notified the DON, the NHA, the police and the resident's guardian.</p> <p>At 6:10 p.m. the police and the DON arrived at the facility. The police were given the resident's face sheet and a description of the resident.</p> <p>On 1/11/25 at 10:15 p.m. a staff member saw Resident #1 on the side of the road in a downtown area approximately five miles from the facility and notified the NHA and the police.</p> <p>At 10:30 p.m. the police arrived and spoke with Resident #1 and the staff member. The guardian's number was provided and the staff member told the police the guardian wanted Resident #1 to be taken to a hospital once she was found.</p> <p>The facility began investigating the situation on 1/11/25 and developed a QAPI plan which included a PIP on 1/13/25.</p> <p>V. Staff interviews</p> <p>The NHA, the SSD and the corporate consultant (CC) were interviewed together on 2/11/25 at 11:40 a.m. The SSD said the staff were doing their normal rounds on 1/10/25 and were unable to locate Resident #1. She said the staff searched the facility and expanded the search to the community. She said Resident #1 was located and the facility's driver returned the resident to the facility. The SSD said the resident was assessed by the provider and placed on 15-minute checks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The NHA said he received a phone call on the same day, but later in the evening, that the staff were unable to locate Resident #1 when the staff were completing their 15-minute checks. He said the resident's guardian and the police were notified that Resident #1 was unable to be located on 1/10/25. The NHA said on 1/11/25 he received a phone call from a staff member who was driving home and spotted Resident #1 on the side of the road in a downtown area. He said the staff member stayed with Resident #1 until the police arrived and then asked the police to take the resident to the emergency room , per the resident guardian's request.</p> <p>The NHA said Resident #1 did not return to the facility after the resident's guardian requested she be taken to the hospital on 1/11/25 and was placed in a sister facility with a secured unit per the guardian's request. The NHA said Resident #1 had never left the facility prior to 1/10/25 and did not have a history of eloping. He said the first time Resident #1 left the facility was because a staff member was buzzed out and Resident #1 followed behind the staff member. He said the second time Resident #1 left the facility, the nurse failed to look at the camera to see who was trying to be buzzed out and just opened the door.</p>		