

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Crestmoor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 895 S Monaco Pkwy Denver, CO 80224	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm 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 observations, interviews, and record review the facility failed to ensure an environment free of accident hazards for one (#3) of three residents reviewed for accidents/hazards out of 16 sample residents. Specifically, the facility failed to prevent Resident #3 from eloping from the facility. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 7/8/26 to 7/9/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/23/26. I. Elopement incident on 3/21/26 On 3/21/26 at 3:30 p.m. the facility failed to ensure a staff member kept a door alarmed, which resulted in Resident #3, who had a wander prevention device, eloping from the facility. Resident #3 eloped from the facility and wandered in the community for approximately a half an hour. The resident was found by a staff member approximately 0.4 miles away from the facility. The resident had no injuries noted and was returned to the facility. Video review revealed that a dietary aide used the keypad to unlock the entryway to the breezeway. Resident #3 followed the dietary aide through the doors and appeared to be speaking with the dietary aide before exiting the facility. The video revealed that the dietary aide did not attempt to redirect Resident #3 back into the facility. II. Facility plan of correction The corrective action plan the facility implemented in response to Resident #3's elopement incident on 3/21/26 was provided by the assistant nursing home administrator on 7/8/26 at 11:00 a.m. The plan documented the following: A. Immediate action to correct the deficient practice for Resident #3 On 3/21/26 when Resident #3 returned to the facility, the resident was placed on 15-minute checks by staff. The staff examined and determined the exit door alarms worked correctly. The staff placed signage on all six exit doors to remind staff and visitors to be mindful of who might exit with them. The four residents with wander prevention devices had their devices checked and all devices functioned correctly. On 3/23/26 at 8:45 a.m. the video footage was reviewed. It was determined that a dietary aide had used a code to turn the alarm off for an exit door as Resident #3 followed the staff member through the doors. The resident appeared to speak to the dietary aide before the facility was exited. The dietary aide did not attempt to redirect Resident #3 back into the building. The dietary aide did not work in the facility after that day (3/21/26). B. Identification of other residents On 3/21/26 the other three residents in the facility with wander prevention devices had their devices checked and all devices worked correctly. The exit doors were checked and also worked correctly. Signs were placed on six exit doors to remind anyone leaving the facility to be mindful of who might be near the exit. On 3/23/26 all facility doors and resident wander prevention devices were assessed and tested by the assistant nursing home administrator and the director of nursing (DON) for proper device functions. On 3/23/26 the elopement binders were reviewed and updated to ensure that all residents who were at risk for elopement/wandering were identified. The binders were located at the front reception desk, (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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