

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Regent Park Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S Interocean Ave Holyoke, CO 80734	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262</p> <p>Based on record review and interviews, the facility failed the to report alleged violations of misappropriation of property to the proper authorities, including the police and the State Survey and Certification Agency, in accordance with state law for one (#97) of three residents reviewed for missing property out of 19 sample residents.</p> <p>Specifically, the facility failed to report an allegation of misappropriation of property to the State Agency, adult protective services or the local police when Resident #97 reported he was missing \$750.00 from his wallet.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 11/7/24 at 8:39 a.m. The policy revealed the facility did not condone resident abuse and should take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends or any other individuals.</p> <p>Residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms.</p> <p>Misappropriation of resident property was defined as the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Misappropriation included, but was not limited to, theft, fraud and financial exploitation.</p> <p>If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Reporting could be completed verbally or in writing.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately was defined as within two hours of an allegation involving abuse or resulting in serious bodily injury or within 24 hours of an allegation that did not involve abuse or result in serious bodily injury.</p> <p>Notification was also made to the following persons and agencies within the time frames defined by regulation or statute: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, adult protective services (where state law provides jurisdiction in long-term care), law enforcement officials (for all abuse allegations), the resident's attending physician and the medical director (when necessary).</p> <p>In addition to an investigation by the police department, the facility would conduct an internal investigation. While the investigation was ongoing, the alleged assailant would have interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation would include interviewing any staff members, residents or family members who may have knowledge of the incident. Results of all investigations would be reported to the administrator or his or her designated representative and to other officials in accordance with state law, including to the State Survey Agency, within 5 (five) working days of the incident, and if the alleged violation was verified, appropriate corrective action would be taken.</p> <p>II. Resident #97</p> <p>A. Resident status</p> <p>Resident #97, age greater than 65, was admitted on [DATE] and discharged home on 10/23/23. According to the October 2023 computerized physician orders (CPO), diagnoses included motorcycle injury in a traffic accident, traumatic subdural hemorrhage (brain injury), fracture of thoracic vertebra, multiple right side rib fractures, fracture of the neck, atrial fibrillation and quadriplegia.</p> <p>The 8/11/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.</p> <p>B. Resident interview</p> <p>Resident #97 was interviewed by phone on 11/4/24 at 11:39 a.m. Resident #97 said he had \$750.00 in a wallet that was placed in a drawer in his room during his stay at the facility. He said he did not carry the wallet with him. He said someone would have had to go into the drawer to retrieve the money from his wallet. He said he did not have a lock box in his room. He said he knew he should not have kept that much money in his room at the facility, however, he said he had needed the money to pay some bills. He said a friend came to help him pay his bills after he was discharged from the facility and that was when he discovered the money was missing. Resident #97 said after he discovered the money was missing from his wallet, he called the facility to report it.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Acknowledgement Form Admission Packet signed by Resident #97 on 8/7/23 revealed the facility could not guarantee the safety of personal property and the facility was not responsible for the loss of personal property except as required by applicable federal and state law. If a resident would like insurance protection covering the loss of property, it was the resident's responsibility to obtain such insurance. It was the right of each resident to manage his or her own financial affairs. If the resident was unable to manage their personal affairs or if a resident did not want to manage their personal affairs themselves, the facility had a resident trust fund account that the facility would manage in accordance with federal and state laws. If the resident chose to participate in this program, the monies would be kept in an interest bearing account that was separate from the facility's funds, and the resident would receive quarterly statements of the account.</p> <p>A care plan for discharge, initiated on 5/24/23, revealed the resident was planning to discharge to another state where he independently lived alone. The plan did not reveal the resident had mentioned any missing monies.</p> <p>A review of Resident #97's personal property inventory sheet, dated 8/7/23, did not reveal the resident had \$750.00 dollars when he was admitted to the facility. The resident initialed the sheet.</p> <p>The resident's discharge summary, dated 10/23/23 at 10:27 a.m., did not reveal the resident had discussed any missing monies with staff members. The summary revealed the resident said he had no questions or concerns at the time of his discharge from the facility.</p> <p>The multidisciplinary care conference, dated 10/18/23 at 1:10 p.m., revealed a discussion took place regarding Resident #97's overall progress with skilled therapy services and discharge planning. There was no documentation that the resident had reported any missing money.</p> <p>A complaint/concerns report, dated 10/25/23 at 10:15 a.m., revealed the resident called the facility that morning (10/25/23) and said the facility stole \$750.00 dollars from him. The report documented that the resident said he was discharged to his home in another state and he wanted to talk with the NHA today (10/25/23).</p> <p>The Misappropriation of Property Occurrence/Abuse form was provided by the NHA on 11/6/24 at 5:49 p.m. The form revealed the first known date and time of Resident #97's allegation of missing \$750.00 was 10/25/23 at 10:00 a.m. The form further revealed the resident was discharged on [DATE].</p> <p>The Misappropriation of Property Occurrence/Abuse form included interviews of residents and staff. None of the residents who were interviewed reported any concerns of missing money or property. None of the staff members who were interviewed reported any knowledge of Resident #97 having \$750.00 in his wallet during his stay at the facility.</p> <p>Review of the State Survey Agency database on 11/4/24 failed to show evidence the facility had reported the alleged misappropriation of property involving Resident #97 to the State Agency as required.</p> <p>D. Staff interview</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA was interviewed on 11/6/24 at 4:07 p.m. The NHA said on 10/25/23 at 10:15 a.m., Resident #97 called the facility and said someone had stolen \$750.00 dollars from him. The NHA said the resident said he had the money when he arrived at the facility. The NHA said 10/25/23 was the first time she was made aware of the missing money.</p> <p>The NHA said Resident #97 told her that he did not know the \$750.00 dollars was missing until he arrived at his home after being discharged from the facility. The NHA said the resident's belongings inventory sheet did not reveal he had \$750.00 dollars when he entered the facility.</p> <p>The NHA said during care conferences and during the discharge meetings, Resident #97 never said he was missing any money. The NHA said neither she nor any of her staff had seen the money the resident referred to. She said she did a thorough misappropriation of property investigation and none of the interviewed staff had ever seen the resident's money and none of the interviewed residents had any missing items. The NHA said Resident #97 did not have a roommate during his stay at the facility.</p> <p>The NHA said upon admission, Resident #97 was offered a lock box for his room, however the resident refused. The NHA said the resident was offered the use of a trust account to put any money he had into the fund and the resident refused. The NHA said she called the previous facility that the resident resided at and was informed that they had no record of the \$750.00 dollars and the resident did not have a trust account with that facility.</p> <p>The NHA said, to her knowledge, the money did not exist because she was unable to find anyone who had seen the money. The NHA said while Resident #97 resided in the facility, the resident never said he had missing money. The NHA said she was not able to prove that Resident #97 did or did not have the money at the facility.</p> <p>The NHA said the facility completed an investigation after Resident #97 called and reported the missing money, however, she said she did not report the incident to the State Agency occurrence reporting portal because it did not meet the reporting criteria.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48458</p> <p>Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in accordance with professional standards in one of one medication storage rooms.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Maintain the emergency medication kit with medications that had not expired; and, -Ensure the emergency medication kit did not have two different expiration dates on individual packages which were prepared by the pharmacy. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Labeling and Storage policy, revised February 2023, was provided by the director of nursing (DON) on 11/6/24 at 3:35 p.m. The policy read in pertinent part,</p> <p>The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.</p> <p>The medication label includes at a minimum the medication name, prescribed dose, strength, expiration date, when applicable, resident's name, route of administration and appropriate instructions and precautions.</p> <p>II. Observations and interview</p> <p>On 11/5/24 at 9:06 a.m. the medication storage room was observed with registered nurse (RN) #1. The emergency medication kit had a yellow label on the outside of the kit which revealed there were medications within the kit that expired in October 2024. The kit contained approximately 100 individually packaged medications that had been prepared by the pharmacy.</p> <p>The following items were found in the emergency kit:</p> <ul style="list-style-type: none"> -Two individual pill packages of ciprofloxacin (an antibiotic medication) 250 milligrams (mg) with an expiration date on the label of 3/31/23. A second expiration date of September 2024 was also printed on the label. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Three packages of levofloxacin (an antibiotic medication) 250 mg all revealed an expiration date on the labels of October 2024. There were no additional expiration dates on the packages.</p> <p>RN #1 said the medications were expired and she did not know which expiration date was accurate for the medication labeled with two expiration dates. She said expired medications could be less effective if they were given to residents.</p> <p>Additional findings found in the emergency medication kit included the following:</p> <p>-Two packages of ciprofloxacin 500 mg with two expiration dates on the label of 10/1/24 and March 2025.</p> <p>-One package of levofloxacin 500 mg with two expiration dates of October 2024 and 9/6/25.</p> <p>-Three packages of albuterol sulfate inhalation solution (medication used to treat respiratory conditions) 0.083%, 2.5 mg with one expiration date on the label of 8/22/24 and an expiration date on the package of January 2025.</p> <p>-Seven packages of metoprolol (a blood pressure medication) 25 mg with two expiration dates on the label of 10/1/24 and March 2026.</p> <p>-One package of Cefuroxime (an antibiotic medication) 500 mg with two expiration dates on the label of 10/1/24 and March 2025.</p> <p>-One package of cephalexin (an antibiotic medication) 250 mg with two expiration dates on the label of 8/22/24 and December 2024.</p> <p>-Ten packages of clindamycin (an antibiotic medication) 150 mg with two expiration dates on the label of 4/26/24 and August 2025.</p> <p>RN #1 said the package labels were confusing because there were two expiration dates on the labels. She said she was not certain if the medications had expired or not because one of the expiration dates was in the past and the other expiration date was dated in the future.</p> <p>III. Staff interviews</p> <p>The pharmacist (PH) was interviewed on 11/5/24 at 9:40 a.m. The PH said the pharmacy department had a list of all medications in the facility's emergency medication kit and a member of the pharmacy team checked the kit monthly for medications that were due to expire. The PH said the pharmacy department was not onsite at the facility during the month of October 2024 to review the expiration dates in the emergency medication kit. The PH said the three levofloxacin 250 mg medication packages and the two ciprofloxacin 250 mg medication packages were expired and had been overlooked when they last checked the kit in September 2024. The PH said the pharmacy and the facility were responsible for checking expiration dates of medications within the emergency kit.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The PH said the accurate expiration date was the later of the two dates on each of the packages. She said the earlier expiration date on the packages reflected an automatically generated date when the labels were created. The PH said the two expiration dates on one medication label could create confusion for the nursing staff when they checked expiration dates. She said she would relabel the medications with one expiration date to eliminate any confusion.</p> <p>The DON was interviewed on 11/5/24 at 10:30 am. The DON said it was confusing to have two different expiration dates on the emergency medication kit medication packages and she did not know which expiration date was correct.</p> <p>The DON was interviewed again on 11/7/24 at 9:57 a.m. The DON said the pharmacy had the responsibility of reviewing emergency medication kit expiration dates once per month. The DON said nursing staff should check the expiration dates on medications that were removed from the kit for use or if nursing staff added any replacement medications to the kit received from the pharmacy.</p> <p>IV. Facility follow up</p> <p>On 11/5/24 at 1:20 p.m. the DON provided an example of new emergency medication kit labels made by the PH which contained only one expiration date. The DON said all of the labels on the emergency kit medications had been corrected to one expiration date (during the survey).</p> <p>On 11/7/24 at 9:57 a.m., the DON said the pharmacy was going to begin removing medications from the emergency kit one month prior to the expiration date.</p>