

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Irondale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Poplar St Commerce City, CO 80022	
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 - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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: 065318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Irontdale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Poplar St Commerce City, CO 80022	
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 - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#4) of three residents reviewed for elopement out of three sample residents and other residents residing in the facility remained as free from accidents/hazards as possible. Specifically, the facility failed to: -Ensure Resident #4 received adequate supervision to prevent the resident from eloping from the facility; and, -Ensure there was an effective evacuation plan in place and that staff were trained on the plan and provided with the necessary equipment to evacuate residents from the facility in the case of an emergency, which had the potential to affect the safety of all 72 residents residing in the facility. ELOPEMENT INCIDENT FAILURE FOR RESIDENT #4 Resident #4, who had diagnoses of bipolar disorder, cognitive communication deficit, chronic heart failure, presence of automatic implanted cardiac defibrillator and traumatic subarachnoid hemorrhage (bleeding between the brain and the protective layer of the brain), was admitted to the facility on [DATE]. Upon admission, Resident #4 was assessed to be at high risk for elopement due to exit seeking behaviors and verbalizing the desire to leave the facility. The facility implemented a care plan on 6/26/25 of the resident's impulsive behavior problem, which included behaviors such as a history of eloping, threatening to elope, refusing care and throwing his plate of food. However, the facility failed to implement appropriate resident-specific interventions to provide adequate supervision and monitoring to meet the resident's individual needs when Resident #4, who resided on the secured unit, was distressed/upset and voiced desire to leave the facility, refused/throw his plate of food. On 9/20/25 at 4:30 p.m. threw his dinner meal when he was agitated. The resident tried to reach out to his family via phone but they did not answer and his agitation grew. The facility failed to adequately respond to the resident's distress and did not provide increased safety oversight, including frequent checks, monitoring or behavioral support. Staff failed to provide consistent monitoring of the resident for approximately four hours after he was noted to have escalating agitation (see facility investigation below). Resident #4 was officially designated as missing from the facility on 9/20/25 at 8:30 p.m. Per the facility investigation conducted after the resident's elopement, the facility believed that Resident #4 eloped the facility through his window by overriding the safety mechanism and then climbed over a gate in the secured courtyard. The facility was not aware that he was missing for four hours. Resident #4 was not found until two days later at a homeless shelter and was missing for approximately 46 hours (see facility investigation below). Resident #4 did not return to the facility. The facility's failure to provide adequate supervision, implement the elopement care plan, monitoring the resident after a behavioral event created a situation where serious adverse outcome was likely. The resident had acute health concerns that went unaddressed as a result of his elopement. SAFE AND EFFECTIVE EVACUATION ROUTE PLAN FAILURE During the investigation of Resident #4's elopement, staff interviews revealed the facility failed to have a plan that ensured the safe evacuation of residents from the facility in the event of an emergency. Observations revealed the facility was on one level and was divided into two unsecured nurse units (Castle Rock and Red Rocks) and one secured unit (Rocky Mountain). Fifty-five residents resided on the two unsecured units and seventeen residents resided on the secured unit. There were no evacuation floor plans or maps posted on any of the walls in the facility. There were no maps or floor plans posted with directional arrows that demonstrated the path staff and residents should follow in the event of an evacuation. Interviews with staff revealed they were not aware of the routes to take to evacuate residents from the building in the event of an emergency. Observations revealed the gate in the secured unit courtyard, which was the primary emergency egress/evacuation route for the Rocky Mountain unit and the Castle Rock unit, was padlocked, preventing staff and residents from exiting the courtyard. Additionally, staff was unaware of where the key for the padlock was located. The facility's failure to have a plan that ensured the safe evacuation of residents and to ensure the primary egress route for emergency exits for the secured unit remained unlocked and accessible created a hazardous environment that made serious harm likely. The facility failed to provide Resident #4 with the supervision necessary to prevent an elopement. Furthermore, there was a padlock placed on the primary evacuation/egress route from the secured unit via the courtyard through the outdoor fenced storage area. The facility's failures created a situation for the likelihood of serious harm to residents' health and safety if the situation was not immediately corrected. Findings include: 1. Immediate Jeopardy A. Findings of immediate jeopardy ELOPEMENT Upon admission, Resident #4 was assessed to be at high risk for elopement due to exit seeking behaviors and verbalizing the desire to leave the facility. The facility</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Irondale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Poplar St Commerce City, CO 80022	

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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Irontdale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Poplar St Commerce City, CO 80022	
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on interviews and record review, 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 performance improvement (QAPI) program committee failed to identify and address concerns related to: -Accident/hazards in which the facility failed to provide Residents #4 the supervision necessary to prevent elopement that rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely; and, -Accident/hazards in which the facility failed to have a system in place to ensure the staff followed the facility emergency plan regarding evacuation procedures and physical barriers (padlock) in place that prevented staff and residents from evacuating the premises which rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely. Findings include: 1. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) policy and procedure, revised December 2024, was provided by nursing home administrator (NHA) #1 on 10/9/25 at 3:55 p.m. It read in pertinent part, The facility will establish and implement a quality assessment and assurance committee, develop a written QAPI plan, which will be used to continually assess the facility's performance using a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. The plan will be reviewed and updated annually. QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system. QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes. Quality Assurance (QA) is the specification of standards for quality of service and outcomes, and systems. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards. Performance Improvement (PI) is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. Procedure: Quality Assessment and Assurance Committee (QAA): Members of the committee will include: director of nursing (DON), medical director, administrator, Infection preventionist, at least two other members: Staff with responsibilities for direct resident care and services (CNAs (certified nurse aides), therapists, staff nurses, social workers, activities staff). Staff with responsibilities for the physical plant (maintenance, housekeeping, laundry). The committee will meet at least quarterly or more often as the facility deems necessary. The committee will maintain a record of the dates of all meetings and the names/titles of those attending each meeting. Committee functions include: QAPI plan, identifying and prioritizing Process Improvement Plans (PIPs), implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained. QAPI plan components: The plan will include: Design and scope to include: Address all systems of care and management practices; Include clinical care, quality of life and resident choice; Utilize the best available evidence to assist in defining goals and desired outcomes; and Reflect the care and services provided by the facility. Establishing goals and thresholds for performance measurement. Feedback, data systems, and monitoring demonstrating evidence of identification, reporting, investigating, analysis, and prevention of adverse events. Performance improvement projects (PIPs or QITs) to demonstrate corrective actions and/or improvement activities. At least one project annually must focus on high-risk or problem-prone areas, identified by the facility through data collection and analysis. Systematic analysis and systemic action of identified quality deficiencies. Identification of, and prioritizing of, PIPs through: Open-door policy for staff reporting of quality problems; Staff meetings; Resident council; Grievances; Systematic review of facility data, data sources, and comparative data, from market, state, and national sources. Prioritizing through identification of high-risk, high volume, or problem-prone issues. Education and information sharing: Staff will be educated on QAPI (Committee, Plan, and PIPs) at the time of hire, as needed, and annually thereafter. QAPI plans and activities will be shared through resident council. QAPI plans and activities may be shared through staff meetings, bulletin boards. Governance and leadership: a. The governing board and administrator will promote and create a fair and open culture where staff are comfortable identifying quality problems and opportunities. The administrator will provide support for staff time, space, and resources to</p>		