STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Village - the Spearly Center	2205 W 29th Ave Denver, CO 80211

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 - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 37166 Based on observations, record review, and interviews, the facility failed to ensure that one (#1) of three sample residents and other residents residing on the facility's third floor remained as free from accidents as possible. Resident #1 was admitted to the facility on [DATE] for long-term care. The resident was severely cognitively impaired and impulsive with poor safety awareness. At the time of admission, he was assessed not to be at risk for elopement. However, after admission, staff reported he was always on the move, standing near the doors and observing people passing in and out. By [DATE], the resident had become increasingly agitated and made several attempts to leave, setting off alarms when he attempted to open the doors. At approximately 1:08 p.m. that day, the resident eloped from the facility. Video surveillance revealed the resident, wearing shorts, a short-sleeved shirt, and flip-flops, followed a staff member through the emergency exit door (kitchen delivery door) on the first floor before the door, which was on a 15-second delay, relocked. Attempts to locate and contact the resident by phone were unsuccessful. He was located by the police two days later ([DATE]), approximately ten miles away from the facility, in critical condition. The resident was transported to the hospital by ambulance where he was pronounced deceased . The facility failed to provide the resident with adequate services and support to prevent his elopement. Despite staff knowledge of the resident's escalating behaviors on [DATE], their interviews revealed a conflicting understanding of the resident's level of supervision that day, and progress notes and care plans failed to document interventions to minimize his safety risk. The facility further failed to take adequate steps after [DATE] to prevent additional elopements. According to the director of nursing (DON), since the incident on [DATE], all staff had received education to wait 15 seconds after exiting the emergency door to ensure the door was locked, and a sign was placed on the doors as a reminder. However, on [DATE] at 12:35 p.m. (during the survey), observations revealed an unlocked door to the boiler room next to the emergency exit door. Another door in this room led to the outside. Both doors were unlocked and not secured with an alarm. All residents from the third floor had access to the unlocked doors. According to the nursing home administrator (NHA), the boiler room door was to be locked at all times and she was unclear why it had been left unlocked. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility failures above created a situation of immediate jeopardy for serious harm, for Resident #1 and widespread potential for serious harm for facility residents on the third floor, that required immediate corrective action. Findings include: IMMEDIATE JEOPARDY I. Immediate Jeopardy A. Findings of immediate jeopardy Resident #1 was admitted to the facility on [DATE] for long-term care. The resident was severely cognitively impaired and impulsive with poor safety awareness. At the time of admission, he was assessed not to be at risk for elopement. However, after admission, staff reported he was always on the move, standing near the doors and observing people passing in and out. By mid-day on [DATE], the resident had become increasingly agitated and made several attempts to leave, setting off alarms when he attempted to open the doors. At approximately 1:08 p.m. that day, he eloped from the facility. Video surveillance revealed the resident, wearing shorts, a short-sleeved shirt, and flip flops, followed a staff member through the emergency exit door (kitchen delivery door) on the first floor before the door, on a 15-second delay, relocked. Attempts to locate and contact the resident by phone were unsuccessful. He was located by the police two days later, approximately ten miles away from the facility in critical condition. The resident was transported to the hospital by ambulance where he was pronounced deceased . The facility failed to provide the resident with adequate services and support to prevent his elopement. Despite staff knowledge of the resident's escalating behaviors on [DATE], their interviews revealed a conflicting understanding of the resident's level of supervision that day and progress notes and care plans failed to reveal interventions to minimize his safety risk. The facility further failed to take adequate steps after [DATE] to prevent additional elopements. According to the director of nursing (DON), since the incident on [DATE], all staff had received education to wait 15 seconds after exiting the emergency door to ensure the door was locked and a sign was placed on the doors as a reminder. However, on [DATE] at 12:35 p.m. (during the survey), observations revealed an unlocked door to the boiler room next to the emergency exit door. Another door in this room led to the outside. Both doors were unlocked and not secured with an alarm. All residents from the third floor had access to these unlocked doors. According to the nursing home administrator (NHA), the boiler room door was to be locked at all times and she was unclear why it had been left unlocked. The facility failures above created a situation of immediate jeopardy for serious harm, for Resident #1 and widespread potential for serious harm for facility residents on the third floor, that required immediate corrective action. B. Facility plan to remove the immediate jeopardy (continued on next page)

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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 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. 37166 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 facility's QAPI policy was requested from the nursing home administrator (NHA) on 12/11/24 at 4:50 p. m. -However, the policy was not provided as requested. II. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies in F689 Accidents/Hazards. During a recertification survey on 5/23/24, F689 was cited at a L level scope and severity, immediate jeopardy to resident health or safety, widespread. During an abbreviated survey on 10/23/24, F689 was cited at a G level scope and severity, actual harm, isolated. III. Cross-referenced citations Cross-reference F689: The facility failed to prevent an elopement of the resident. On 11/30/24 Resident #1 left the facility by following a staff member through the back emergency exit door on the first floor. He was located by the police two days (12/2/24) later, approximately ten miles away from the facility, in critical condition. He passed away in the hospital upon arrival. Observations of the facility on 12/10/24 revealed the boiler room door was unlocked. The additional door in the boiler room was unlocked as well and led to the outside. The facility's failure to ensure staff were waiting 15 seconds for the door to lock behind them after exiting through the emergency exit and the failure to keep the boiler door locked at all times, created a situation of immediate jeopardy with widespread potential for serious harm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	12/11/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	IV. Interviews The director of nursing (DON) and the NHA were interviewed together on 12/11/24 at 4:38 p.m. The DON said a comprehensive elopement assessment was completed by social services. Residents were observed for seven days after admission to establish a baseline of their behavior. He said if anything was observed that would require an intervention, it was usually discussed in daily meetings. The NHA said once the incident with Resident #1 was identified on 11/30/24, staff reviewed the resident's record, and all met for daily interdisciplinary team (IDT) meetings and discussed the incident. She said it was identified throughout the investigation that the staff member that Resident #1 followed through the door did not follow the 15-second rule after exiting through the emergency exit door and he did not check if anyone was following him. She said the staff member was educated on the 15-second rule upon hire and provided the education log for the staff member. The NHA said the staff member and all other staff in the building were educated and reminded to wait 15-seconds after exiting through the emergency exit doors. She said signs were placed on all doors throughout the building as a reminder to staff. The DON said, starting on 12/10/24, the facility started education for all staff to ensure they were aware of residents at risk for elopement on all units. He said binders were created with pictures and care plans of residents who were identified as at risk for elopement. The DON said all staff were educated on specific interventions that were in place and the location of the binders at the nurses station. The NHA said the incident was initially reviewed in QAPI on 11/30/24 and the facility identified several missing points from the records, such as detailed behavior with interventions was not documented, the resident was not monitored consistently in the unit, staff on the other units were not aware of Resident #1's elopement risk and several nursing notes were completed after the resident eloped from the building. The NHA said corrective action in response to Resident #1's elopement started on 11/30/24 and continued throughout 12/10/24. V. Facility follow up On 12/11/24 at 4:50 p.m., during the survey, the NHA provided a copy of the quality measure report. The report was initiated on 11/30/24 after Resident #1 eloped from the building. The report indicated that the facility identified poor documentation for timeline of events, delay in obtaining as needed medications, failure to monitor resident on the unit, staff from other units being unaware of residents who were at risk for elopement and staff not waiting for the exit door to alarm before walking away. The education to all staff on ensuring exit alarms reengaged before walking away doors was completed on 12/3/24. The protocol was initiated to share information between units on residents unable to leave units on 12/5/24.