STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065347	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health Care Center, Inc	2120 N 10th St Canon City, CO 81212

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf for one (#8) of four residents reviewed for personal funds out of 17 sample residents. Specifically, the facility failed to provide Resident #8 a copy of her personal funds statement on at least a quarterly basis. Findings include: I. Resident status Resident #8, age 72, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included major depressive disorder and borderline personality disorder. The 1/28/25 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. She required no assistance with her activities of daily living (ADL). II. Resident interview Resident #8 was interviewed on 2/25/25 at 10:47 a.m. Resident #8 said she was supposed to get a personal funds statement every three months and she had not received a statement from the facility since June 2024. She said it had been seven months since she had received her last statement. She said the business office manager (BOM) was responsible for printing out the personal funds statements. Resident #8 said when she had asked for a personal funds statement, it took the business office two months to print it out. She said she was frustrated with the process. She said she should not have to ask for her personal funds statements and she should automatically get them. III. Record review (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's electronic medical record (EMR), under the business office task dated 4/18/24, revealed a resident personal funds statement for the period of 12/30/23 to 3/29/24. Resident #8 signed off that the statement was received, however, there was no date documented for when the resident signed it. There was no further business office documentation in Resident #8's EMR. On 2/26/25 at 10:56 a.m. a request was made to the BOM for documentation regarding when Resident #8 received her quarterly personal funds statements. -The facility was unable to provide documentation to show that Resident #8 had received her quarterly statements. IV. Staff interviews The BOM was interviewed on 2/25/25 at 4:12 p.m. The BOM said she was in charge of making sure residents received personal funds account statements. The BOM said residents got a copy of their personal funds statement when they asked for it. However, she said she sent out personal funds statements to residents every month. The BOM was interviewed a second time on 2/26/25 at 10:56 a.m. The BOM said she was not sure when Resident #8 last received a personal funds statement. She said she would have to look into it. The nursing home administrator (NHA) was interviewed on 2/26/25 at 9:17 a.m.The NHA said residents could request a personal funds statement at any time. The NHA said she did not know how often residents should receive personal funds statements from the facility. She said resident fund management services (RFMS) was run by the corporate office. She said the corporate office was responsible for sending out residents ' personal funds statements. The NHA said she did not know that residents should receive personal funds statements on a quarterly basis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations and interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment in seven of 26 resident rooms and damaged areas in one of two resident halls out of two units. Specifically, the facility failed to: -Ensure blinds were intact in seven resident rooms; and, -Ensure the heating vents were intact and not falling off the heating units. Findings include: I. Facility policy and procedure The Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 2/26/25 at 5:26 p.m. It read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment. II. Environmental tour and interview The environmental tour was completed on 2/25/25 at 9:30 am and again on 2/26/25 at 9:52 a.m. The following was observed: Resident rooms #6, #10, #11, #19, #22, #23 and #28 had broken window blinds that were yellow and heavily soiled with dust and debris. The window blinds in the dining room were broken and dusty. Resident room [ROOM NUMBER] had a broken doorframe and the heating units just outside of rooms #18 and #19 were bent and coming off the wall. The ceiling on the right side hallway where the mechanical lifts were stored had an approximate three-inch hole punched in the ceiling and the heating cooling vent in the ceiling was cracked. III. Resident interview The resident in room [ROOM NUMBER] said their blinds were very dusty, it bothered them and they had wanted it to be cleaned for a while. IV. Staff interview (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 2/26/25 at 5:33 p.m. The NHA said the facility was without a permanent maintenance director and was in the process of promoting a current staff member to the position. The NHA said she would take a look at the broken blinds and other areas of the facility for needed repairs. The NHA said she would consider the most appropriate type of window covering and get the broken blinds replaced. The NHA said the blinds should be on a routine cleaning schedule.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820 Based on record review and interviews, the facility failed to ensure five (#1,#7, #4, #10 and #3) of 15 residents reviewed for abuse were kept free from abuse out of 17 sample residents. Specifically, the facility failed to: -Protect Resident #1 from physical abuse by Resident #6 and Resident #2; -Protect Resident #7 from physical abuse by Resident #2; -Protect Resident #4 from physical abuse by Resident #5; -Protect Resident #10 from physical abuse by Resident #11; and, -Protect Resident #3 from verbal abuse by a staff member. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 2/25/25 at 9:57 a.m. It read in pertinent part, The community does not condone resident abuse and shall 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 representatives, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of residents' property and exploitation. This includes, but is not limited to, freedom of corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Employees have a unique position of trust with vulnerable residents. II. Failed to protect Resident #1 from physical abuse by Resident #6 A. Incident of physical abuse between Resident #1 and Resident #6 on 1/24/25 On 1/24/25 at 4:40 a.m. Resident #1 went into Resident #6's room. Resident #1 climbed into bed with Resident #6. Resident #6 became upset and began to hit Resident #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified nurse aide (CNA) #6's interview indicated Resident #1 went into Resident #6's room while Resident #6 was sleeping and got into bed with him. CNA #6 heard Resident #1 say wait, stop. As CNA #6 entered the room, Resident #1 was lying on the bed and Resident #6 was sitting up punching Resident #1 in the face. CNA #6 held Resident #6's hands and pulled Resident #1 up out of the bed. As CNA #6 was doing so, Resident #6 hit Resident #1 in the kidney area three more times. CNA #6 took Resident #1 to his room and put him into bed. Upon assessment, no injuries were noted on Resident #1 or Resident #6. Resident #1 and Resident #6 were not interviewable. The facility substantiated the abuse. B. Resident #1 (victim) 1. Resident status Resident #1, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included dementia and alcohol cirrhosis of the liver. The 12/12/24 minimum data set (MDS) assessment revealed the resident's cognitive status was severely impaired with a brief interview for mental status (BIMS) score of zero out of 15. The assessment indicated the resident had wandering behaviors. 2. Record review Resident #1's care plan, initiated 9/29/22 and revised 2/7/25, identified the resident was at risk of injury related to wandering. Interventions included redirecting Resident #1 to his room when he was room seeking and staff were to be aware of Resident #1's location and assist him to his room or another safe place as needed. -There were no new interventions added following the 1/24/25 incident with Resident #2. The progress note, dated 1/24/25 at 7:05 a.m., documented that at 4:40 a.m. the CNA on rounds heard the sound of loud hits. The CNA went to investigate and found Resident #1 in another resident's bed. The other resident was hitting Resident #1 in the face. As the CNA was getting Resident #1 out of the other resident's bed, the other resident hit him in the back and kidney area three times. The CNA removed Resident #1 from the room and took him to his room and put him in his bed. The CNA reported the incident to the licensed practical nurse (LPN) on duty. There were no red bruised or open areas noted to the resident's face or back. C. Resident #6 (assailant) 1. Resident status Resident #6, age 76, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia and alcohol cirrhosis of the liver. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/22/25 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of zero out of 15. The assessment indicated the resident had no behaviors. 2. Record review The progress note dated 1/24/25 at 7:22 a.m. documented the CNA doing rounds at 4:40 a.m. heard sounds of loud hits. The CNA went to investigate and found another male resident in Resident #6's bed. Resident #6 was hitting the other resident in the face. As the CNA was getting the other resident out of Resident #6's bed, Resident #6 hit him in the back and kidney area three times. The other resident was removed by the CNA. Resident #6 stated, I think I hit him in the face and back, he wouldn't get out. III. Failed to protect Resident #1 from physical abuse by Resident #2 A. Incident of physical abuse between Resident #1 and Resident #2 on 2/1/25 During the evening shift on 2/1/25 at 3:15 p.m., the nurse on duty heard a resident yelling in the hallway and ran over to investigate. The nurse witnessed Resident #2 standing in the hallway and Resident #1 pointing at Resident #2 and yelling Why? Why? Upon review of video footage, it was determined that Resident #2 was behind Resident #1 walking down the hallway when Resident #2 suddenly started kicking and punching Resident #1 from behind. The residents were separated, an investigation was initiated, 72-hour close monitoring was initiated with Resident #2 and the police were called. A door chime was purchased to help with giving Resident #2 some relief and reassurance that hopefully no other resident would accidentally go into his room. Upon review of video footage, it was determined that the alleged assailant (Resident #2) was behind the victim (Resident #1) walking down the hallway when the alleged assailant suddenly started kicking and punching the victim from behind. The assessment was completed, and there were no injuries noted. Resident #2 was interviewed and said Resident #1 was going into his room so he hit him. Resident #1 was unable to be interviewed. The facility substantiated the abuse. B. Resident #1 (victim) 1. Record review -Review of Resident #1's care plan revealed there were no updates to his care plan following the incident with Resident #2 on 2/1/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note, dated 2/1/25 at 4:01 p.m., documented the nurse, at 3:15 p.m., heard Resident #1 yelling in distress from the hallway. The nurse ran over and Resident #1 was standing and pointing at another resident and yelling Why? Why? and had burrito residue in his hair. Another resident was standing nearby in the hallway and stated I hit him, he was going in my room. Immediately separated residents. A head to toe skin check was done, and no new injuries noted. C. Resident #2 (assailant) 1. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included schizophrenia and anxiety. The 12/4/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of three out of 15. The assessment indicated the resident had no behaviors. 2. Record review Resident #2's physical aggression care plan, initiated 1/28/25, identified the resident had physical aggression toward staff and residents related to the disease process and trauma to phobia. Interventions included reducing stimuli around Resident #2 so he did not have anxiety induced episodes. Resident #2's behavior care plan, initiated 12/7/22 and revised 3/27/24, identified the resident had a behavior problem related to becoming intrusive to others and being physically aggressive. Interventions included Resident #2's triggers for striking out were related to others coming too close to his personal space, Resident #2's behavior was de-escalated by redirecting him from potential or actual altercations, assuring Resident #2 was monitored for aggressive behavior towards other residents and redirected to decrease altercations, intervening as necessary to protect the rights and safety of others, approaching/speaking to Resident #2 in a calm manner, diverting the resident's attention and removing the resident from the situation and taking him to an alternate location as needed. The progress note, dated 2/1/25 at 4:15 p.m. documented the nurse heard a resident yelling, at 3:14 p.m., in the hallway. The nurse ran over and saw Resident #2 standing in the hallway and the other resident was pointing at Resident #2 and yelling, Why? Why? and had Resident #2's food in his hair. When the nurse asked what happened, Resident #2 stated he was going in my room, so I hit him. The nurse separated the residents and placed Resident #2 on one-to-one supervision. Video footage revealed Resident #2 was behind the other resident as he was walking down the middle of the hallway, and then Resident #2 suddenly started kicking and punching the other resident from behind multiple times with no provocation as the other resident staggered away and started yelling out. IV. Failed to protect Resident #7 from physical abuse by Resident #2 A. Incident of physical abuse between Resident #7 and Resident #2 on 1/18/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/18/25 at 2:00 p.m. licensed practical nurse (LPN) #2 heard yelling outside the kitchen doorway. LPN #2 immediately went to investigate and found both residents had already separated. Upon reviewing the camera footage, it was determined that Resident #2 had kicked Resident #7 on the lower leg approximately two times. The residents were separated, the police were called and monitoring was initiated. The residents were separated and assessed. No injuries were noted. Resident #2 was interviewed and said he did not know what happened. Resident #7 did not recall the incident. The facility substantiated abuse. B. Resident #7 (victim) 1. Resident status Resident #7, age 67, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease and dementia. The 11/1/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of six out of 15. The assessment indicated the resident had no behaviors. 2. Record review Resident #7's care plan, initiated 10/26/24 and revised 1/31/25, identified Resident #7 wandered related to Alzheimer's disease. Interventions included identifying patterns of wandering: was it purposeful, aimless, or escapist or was Resident #7 looking for something, intervening as appropriate, distracting Resident #7 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, and providing structured activities, such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. C. Resident #2 (assailant) 1. Record review The progress note, dated 1/18/25 at 3:05 p.m., documented the nurse was charting in the nursing station at 2:00 p.m. when he heard yelling outside by the kitchen doorway. When the nurse immediately ran out to investigate, both Resident #2 and the other resident had already separated. When checking the camera footage, it looked like Resident #2 was walking past the other resident in the doorway and Resident #2 kicked the other resident in the leg one to two times. When questioned, Resident #2 stated I don't know what happened and walked away. Resident #2 placed on a one-to-one supervision. Resident #2's room was on the opposite side of the building from the other resident. V. Failed to protect Resident #4 from physical abuse by Resident #5 A. Incident of physical abuse between Resident #4 and Resident #5 on 1/24/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/25 at 7:04 p.m. Resident #4 entered the doorway of Resident #5's room. Resident #5 pushed Resident #4 out of the doorway causing her to fall. Upon reviewing the video of the altercation, the video revealed Resident #4 entering the doorway of Resident #5's room. Resident #5's hand and arm were seen pushing Resident #4 causing Resident #4 to fall down. Resident #5 refused to be interviewed, and Resident #4 was unable to be interviewed. An assessment was completed and Resident #4 had no injuries. The facility substantiated abuse. B. Resident #4 (victim) 1. Resident status Resident #4, age 74, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease and dementia. The 12/12/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of zero out of 15. The assessment indicated the resident had wandering behaviors 2. Record review Resident #4's care plan, initiated 8/8/24 and revised 11/19/24, identified Resident #4 wandered related to Alzheimer's disease. Interventions included if Resident #4 was seen wandering into other residents' rooms, staff were to redirect her to her room, distracting Resident #4 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, and providing structured activities, such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. The progress note, dated 1/24/25 at 10:31 p.m., documented that at 7:04 p.m. Resident #4 entered the doorway of another resident. He pushed Resident #4 causing her to fall. Resident #4 landed on her left side and hit the left side of her head. Resident #4 was unable to give a description of the altercation. Resident #4 was assessed and neurological checks started. Resident #4 was assisted up and taken to her room and assisted to bed. C. Resident #5 (assailant) 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Wernicke's encephalopathy (low thiamine) and alcohol induced dementia. The 12/6/24 MDS assessment revealed the resident's cognitive status was cognitively intact with a BIMS score of 14 out of 15. The assessment indicated the resident had no behaviors. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

2. Record review

Resident #5's behavior care plan, initiated 6/3/22 and revised 12/9/22, identified Resident #5 had behavioral challenges related to poor impulse control that put the resident at risk for verbal or physical altercations. Interventions included educating Resident #5 to ask for assistance from staff if another resident was being aggressive with him. assisting Resident #5 to develop more appropriate methods of coping and interacting, such as calling nursing staff for assistance if a resident entered his room and taking a minute to think before reacting, if reasonable, discussing the resident's behavior, and explaining/reinforcing why the resident's behavior was inappropriate and/or unacceptable.

Resident #5's physical aggression care plan, initiated 6/3/22, identified the resident had the potential to be physically aggressive due to poor impulse control. Interventions included educating Resident #5 to the consequences of being physically aggressive (pushing or hitting) other residents and modifying the resident's environment, including placing a stop sign on the resident's door to distract other residents from entering.

The progress note, dated 1/24/25 at 9:42 p.m., documented that at 7:04 p.m. a female resident entered the doorway of Resident #5's room. Resident #5 pushed her and she fell to the ground. Resident #5 denied pushing her but it was seen on camera. Resident #5 was put on behavior monitoring for 72 hours. Resident #5 did not want to talk about the incident.

VI. Failed to protect Resident #10 from physical abuse by Resident #11

A. Incident of physical abuse between Resident #10 and Resident #11 on 2/10/25

On 2/10/25 at 12:04 p.m. Resident #10 was in the hallway and was going between the wheelchair of Resident #11 and another resident when Resident #11 struck out with his right arm and made contact with Resident #10's middle finger knuckle. Resident #10 yelled out he hit me, but it does not hurt.

Resident #10 stated Resident #11 hit him and he did not know why. Resident #11 said Resident #10 was calling him names.

The video review revealed Resident #10 was going between two wheelchairs. When he was to the back and right side of Resident #11's wheelchair, Resident #11 swung his arm back, making physical contact with Resident #10.

Resident #11 stated Resident #10 was calling him names. The residents were assessed and no injuries were noted.

The facility substantiated the abuse.

B. Resident #10 (victim)

1. Resident status

Resident #10, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included traumatic brain injury and dementia.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/1/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of zero out of 15. The assessment indicated the resident had no behaviors. 2. Record review Resident #10's care plan, initiated 1/2/25, identified Resident #10 was an elopement risk related to a traumatic brain injury and dementia. Interventions included identifying patterns of wandering: was it purposeful, aimless, or escapist or was Resident#10 looking for something, intervening as appropriate and distracting Resident #10 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. C. Resident #11 (assailant) 1. Resident status Resident #11, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included hypertension and dementia. The 12/18/24 MDS assessment revealed the resident's cognitive status was intact with a BIMS score of 15 out of 15. The assessment indicated the resident had no behaviors. VII. Failed to protect Resident #3 from verbal abuse by a staff member A. Incident of verbal abuse between Resident #3 and a staff member on 12/4/24 On 12/4/24 at 2:50 p.m., it was reported a verbal altercation occurred between Resident #3 and a staff member. A former staff (FS) member interview revealed LPN #1 was at her cart passing medications. Resident #3 walked by and asked her for a styrofoam cup. Resident #3 said his cups were taken. LPN #1 told him she did not take them. Then LPN #1 and Resident #3 started yelling. Resident #3 demanded LPN #1 give him a cup. LPN #1 said no because Resident #3 was a hoarder. LPN #1 continued to yell, then Resident #3 said I'll punch you. LPN #1 stepped toward Resident #3 yelling for him to do it (hit her), repeating the statement several times. The FS member then yelled telling them to separate and for LPN #1 to lock her cart and move it and herself to the nurse's station. Resident #3 went to the men's hall. Resident #3 was assessed and no injuries were noted. The facility substantiated abuse. B. Resident #3 (victim) 1. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3, age 71, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included schizophrenia and dementia. The 1/9/25 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of zero out of 15. The assessment indicated the resident rejected care. 2. Record review Resident #3's care plan, initiated 8/4/23 and revised 4/1/24, identified Resident #3 had paranoid delusions and was suspicious and paranoid. Interventions included caregivers were to provide opportunities for positive interaction and attention, stopping and talking with the resident as they were passing by and monitoring the resident for behavior episodes and attempting to determine the underlying cause. VIII. Staff interviews CNA #1 was interviewed on 2/25/25 at 3:38 p.m. CNA #1 said if there was an altercation between residents, she would separate the residents and ensure they were safe. She said she would call for assistance. She said she would notify the charge nurse. She said she knew Resident #11 could get upset and she had seen him throw a cup. She said she was not familiar with any of the other residents. She said if she witnessed any kind of altercation between a resident and a staff member, she said she would try to remove the resident from the situation and tell the staff member to step away, then report it to the director of nursing (DON). CNA #2 was interviewed on 2/25/25 at 3:47 p.m. CNA #2 said if she saw an altercation, she would separate the residents to make sure they were safe and report the incident to the abuse coordinator. She said when Resident #2 became agitated, she would remove him from the situation and offer him a snack, offer him his room or offer for him to watch television (TV). She said she had not seen any issues with the other identified residents. LPN #1 was interviewed on 2/25/25 at 3:53 p.m. LPN #1 said if she saw an altercation between residents, she would call other staff for assistance, separate the residents, make sure the area and residents were safe and notify the DON and/or the NHA. She said she would start the paperwork, notifications and write a behavior note. LPN #1 said when Resident #11 became upset, it was important to keep him at arm's length from the other residents because he could reach out. She said Resident #2 liked to karate chop when in an altercation with another resident. She said he was aware of other residents who liked to wander around his area of the facility. She said the facility placed a stop sign in front of the doorway as a deterrent for the other residents. She said interventions for Resident #2 included to distract him and to offer him the opportunity to go outside. She said Resident #6 liked to keep to himself. She said she had not seen any behavior from him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 said she and Resident #3 had a previous altercation and she did not work with him anymore. She said Resident #3 did not like her and they had a large disagreement that caused them to both raise their voices and Resident #3 threatened to hit her. She said she had to take training (professional improvement planning) and now the other nurses addressed his needs. She said she had never seen Resident #3 put his hands on anyone. Registered nurse (RN) #1 was interviewed on 2/25/25 at 4:00 p.m. RN #1 said she would address Resident #3's needs knowing the strong dislike Resident #3 had with LPN #1. She said all the nurses worked as a team. She said when any kind of altercation occurred, the staff separated the residents and made sure everyone was safe. She said an assessment would be completed as well as the abuse coordinator would be notified. She said the provider and families were notified also. The NHA, who was also the facility's abuse coordinator, was interviewed on 2/26/25 at 2:50 p.m. The NHA said her staff were to separate the residents and make sure they were safe, to try to de-escalate the situation and try to find out what happened. She said she was to be notified as soon as the situation was safe. She said it was important to try to find triggers to help prevent future altercations and educate the staff on them. She said there had been training with staff on approaches and to give residents space. She said she had been at the facility for around two months and she was working on new approaches with staff. She said it was important to her for all the residents to feel safe in their own home.

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(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 - 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** 41032 Based on record review and interviews, the facility failed to ensure one (#3) of three residents at risk for elopement out of 17 sample residents received adequate supervision and were kept free from elopement. Specifically, the facility failed to provide Resident #3 with the supervision necessary to prevent elopement. The facility's failures created a situation for the likelihood of serious harm to residents' health and safety if not immediately corrected. The facility was a totally secure building specializing in serving residents with severe mental illness, dementia and behavioral health issues. The entire campus had a six-foot high security fence around the whole campus with a wired overhang in the unrestricted front resident space to discourage anyone from climbing over the fence. The back fenced-in areas did not have the wired overhang, but access was restricted in the overnight hours when staff were not able to monitor residents in those areas. Staff and visitors had to be keyed in and out of the front gate. Prior to his admission to the facility on [DATE], Resident #3 was diagnosed with dementia and schizophrenia and had a known history of untreated schizophrenia. He continued to refuse treatment and denied having the diagnosis of schizophrenia. While in the hospital, the resident was assessed to have decisional incapacity with an inability to take care of himself; because of this, he was assigned a court-appointed guardian. While at the hospital awaiting mandated placement, he eloped from the hospital setting and had to be returned to the hospital by a police escort. Resident #3 eloped from the facility on 12/30/24 at approximately 7:15 p.m. and was not noticed to be absent from the facility until 12/31/24 at 11:30 a.m. (approximately 16 hours later) when staff were gathering residents for lunch. After an initial search of the facility and the surrounding neighborhood on the morning of 12/31/24, the facility discovered the resident had spent the night at the local hospital. The hospital assessed the resident, gave him a referral to a local homeless shelter and released him. The resident left the hospital and was found shortly afterward by facility staff wandering in an open field near the hospital. Facility leadership viewed video footage of the outdoor space as a part of their investigation to determine how Resident #3 got out of the secured fencing. The resident was viewed on video surveillance going in and out of the doors to the front yard. He was seen unscrewing the yard lights and poking at the fence. He made several trips in and out of the building to the front fencing. At approximately 7:00 p.m. on 12/30/24, during a time when staff were occupied by an unrelated resident incident, Resident #3 was seen on camera with a packed bag leaving his room and exiting the facility through a nearby door. The resident walked the fence line to the opposite side of the yard until he was out of sight of the camera and was not seen back on camera after that, nor was he observed by any staff anywhere on facility grounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility staff checked the fence where Resident #3 was last seen on camera and discovered two holes in the lower corner where the two pieces of fencing came together. The overhanging guard wire on the top of the fence had been unscrewed and removed. It was the conclusion of the nursing home administrator (NHA) that Resident #3 had used facility silverware to make the holes in the fence and unscrew the security wiring. Then the resident used the holes in the fence to insert his feet, enabling him to pull himself up and climb over the fence where he removed the overhanging security wiring. Findings include: Observations, interviews and record review confirmed the facility corrected the deficient practice prior to the onsite investigation on 2/25/25 to 2/26/25, resulting in the deficiency being cited as past noncompliance with a correction date of 1/2/25. I. Situation of serious harm Resident #3 had been homeless for six years prior to his admission to the facility on [DATE] and expressed a desire to return to the city where he had been living prior to his admission to the facility. The facility failed to ensure that facility staff performed regular checks to ensure residents' presence in the facility, particularly when all residents in the facility were known to have a history of elopement-seeking behavior. An interview with the NHA revealed that the facility staff had stopped conducting resident checks to ensure residents' presence in the facility prior to Resident #3's elopement on 12/30/24. Additionally, the facility was not checking the security fencing that surrounded the entire building for breaches where residents could elope. The facility's failure to prevent Resident #3, who had severely impaired cognition, poor safety awareness and a high risk for an elopement attempt, from leaving the facility unsupervised placed the resident at serious risk of harm, serious impairment or death due to the resident's inability to make sound decisions and ensure his own safety. II. Facility plan of correction The corrective action plan the facility implemented in response to Resident #3's elopement incident on 12/30/24 was provided by the NHA on 2/25/25 at 8:45 a.m. The correction plan revealed the following: A. Immediate action On 12/31/24, the facility began their investigation and developed a root cause analysis to determine the necessary corrective actions. Corrective actions included: -Resident #3 returned to the facility and was placed on one-to-one monitoring, but this made him anxious so the facility placed him on 15-minute checks; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident rounding was reinstated to account for resident location, checking resident count every 15 minutes for two weeks. Initiated 12/31/24; -Fencing repaired. Completed 12/31/24; -Front yard surveillance camera was adjusted to give staff a view of the whole front yard; completed 12/31/24; -Instituting daily inspection of the fencing, repair as needed for 4 weeks. Initiated on 1/2/25; -New lighting was installed to light up a larger area of the yard. Lighting was placed in a location inaccessible to residents to prevent unscrewing of the bulbs. Completed 1/2/25; and, -Education provided to all staff on rounding, elopement prevention and midnight census count; initiated 12/31/24 and completed 1/2/25. B. Identification of others affected The facility determined the deficient practice had the potential to affect all the residents in the facility. C. Systemic changes The director of nursing (DON) and the assistant director of nursing (ADON) educated all of the staff on the staff expectations to provide resident supervision with rounding, and conducting ongoing midnight census - heads in beds count, with all residents in the facility. The elopement book was updated to include all residents in the facility. In the event of a resident elopement, the facility had a packet of pertinent information to provide to emergency personnel to aid in finding a missing resident. The front fencing would be replaced with a like-new eight-foot fence. The estimate was approved for the job to move forward on 2/26/25 and the date of completion was to be determined. D. Monitoring The facility would evaluate the effectiveness of the plan in quality assurance and program improvement (QAPI) committee meetings for three months and implement additional interventions as needed to ensure sustained compliance. III. Facility policy and procedure The Elopement and Wandering policy, dated 2/29/24, was provided by the NHA on 2/26/25 at 3:40 p.m. The policy read in pertinent part, It is a goal of the facility to provide a safe environment using least restrictive measure available in caring for residents who are exhibiting elopement behavior. The facility defines 'wanderers' as residents who move around the facility in a non-goal directed manner, but do not make efforts to leave the premises. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	'Elopers' are defined as residents who make an overt or purposeful attempt to leave the facility and do not have the ability to identify safety risks. If the resident is identified as an elopement risk, the following will be maintained: -Elopement Resident Identification form, including the current color photo, physical description of the resident, as well as approaches for an individualized plan of care will be in the elopement binder; -Implementing and care planning interventions to address safety and decrease the risk of elopement; -A physical restraint use consent shall be obtained from the resident's responsible party if an electronic device is utilized; -A physician order will be required for the use of monitoring the device. The order will include checking the placement of the device every shift and checking the function of the device daily; and, -The care plan will be updated to include that an electronic alarm system is used for resident's safety. IV. Resident #3 A. Resident status Resident #3, age 71, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included schizophrenia, dementia and diabetes. The 1/9/25 minimum data set (MDS) assessment revealed the resident had severely impaired cognitive impairments with a brief interview for mental status score (BIMS) of zero out of 15. The resident was able to express ideas and wants and was able to understand verbal content in conversations. The resident was independent with most activities of daily living (ADL) but needed set-up or clean-up assistance with oral and personal hygiene and supervision with showering. The resident experienced hallucinations and delusions but was not assessed to be aggressive. The resident rejected evaluation of care and wandered daily during the assessment look-back period. The quarterly social services evaluation, dated 1/10/25, documented the resident completed a BIMS assessment and was found to be cognitively intact with a score of 15 out of 15 on the exam. B. Resident observation and interview Resident #3 was interviewed on 2/26/25 at 2:30 p.m. Resident #3 said he left the facility to return to the city where he had previously lived. He said he hopped the fence and started walking towards the highway. He said he had enough money saved to get a bus ticket, but he got thirsty on the way and stopped at the hospital for a drink of water. He said it was his downfall that he stayed at the hospital too long. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3 said the hospital doctor talked to him and he thought the doctor was trying to find out if he was crazy. He said the hospital staff let him sleep in the back on a bed and in the morning he was given a referral to a local homeless shelter. He said he was going to the shelter when the police showed up and started asking him questions. Resident #3 said he did not trust the police because they were not telling him the truth about what was going on. He said he refused a ride with the police and then left the hospital on his own. He said the facility staff caught up with him and brought him back to the facility. Resident #3 said he did not want to move to another facility because he wanted to return to the city where he had several living opportunities and knew where to get a good sandwich. Resident #3 said if you leave the door open for me I will sneak out. On 2/26/25 at 3:33 p.m. Resident #3 was out in the front yard of the facility walking the perimeter of the fence, pushing on the fence and looking up at the overhanging security wiring. C. Record review 1. Care plans Resident #3's comprehensive care plan, initiated 8/1/23, documented that Resident #3 required placement on a secure neighborhood due to dementia and a history of elopement to unsafe environments. Resident #3's guardian wished for him to remain at the facility with no plan for discharge. Interventions included activities staff were to provide scheduled activities within Resident #3's capabilities, reviewing Resident #3 every 180 days by the interdisciplinary team (IDT) for appropriateness of secure unit placement, monitoring Resident #3 for exit-seeking behavior and redirecting him away from doors and promoting engagement in meaningful activity. Resident #3's comprehensive care plan included a care focus for elopement risk, initiated on 8/1/23 and revised 1/3/25. The care focus revealed that Resident #3 was an elopement risk related to previous elopements at a prior facility and a dementia diagnosis. Resident #3 would often express a desire to be outside, even to sleep. Resident #3 was often found walking along the fence trying to manipulate it so he could get out and would acquire objects to help him meet this goal. While wandering, Resident #3 would often look for weakness in the fence or an opportune time to leave the facility. Resident #3 could become agitated when being checked on or monitored. Interventions included identifying patterns of wandering and determining if wandering was purposeful or random without a goal, distracting Resident #3 by offering him the opportunity to sit outside listening to rock music, encouraging exercise, like jogging; and talking about animals (initiated 8/1/23, revised 1/3/25), implementing one-to-one supervision if needed and, if implemented, following the resident at a close enough distance that staff could see Resident #3 and intervene when needed, ensuring staff did not directly follow him and cause an increase in paranoia symptoms, if the one-to-one supervision was upsetting to Resident #3 switching staff members and giving him space (initiated 1/3/25), conducting frequent visual checks on Resident #3 throughout the day and night to ensure location and safety (initiated 2/25/25) and providing active listening when Resident #3 voiced ideations of leaving the facility in order to promote redirection (initiated 2/26/25). 2. Preadmission Screening and Resident Review (PASRR) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The PASRR Level II evaluation, dated 7/23/23, documented that Resident #3 had been living on the streets, was unable to care for himself and ended up in the hospital for treatment of significant swelling in his legs. He had a long history of untreated schizophrenia, with symptoms including paranoid ideation, delusional thoughts, disorganized thinking and speech, flight of ideas and tangential (vague) speech. The assessment further revealed that Resident #3 had problems with his foot but could stand and ambulate independently. He would likely benefit from prompts and set up for showering. He could toilet and complete basic ADLs with little assistance. Due to his symptoms of psychosis, he would benefit from a supervised setting. Resident #3 was in denial about his mental health diagnosis and his need for treatment. Resident #3 lacked insight into his need for more stable housing and need for care. He was resistant to placement in long-term care and wanted to feel independent. Because Resident #3 did not meet the requirements for court-ordered medication, the PASRR assessor recommended the resident be offered an opportunity to accept medications on a voluntary basis. 3. Elopement and wandering risk assessment An elopement risk assessment, dated 1/10/25, revealed Resident #3 was an elopement risk related to previous elopement at a prior facility, dementia diagnosis, and history of being homeless. He spent most of his time outside on facility grounds walking and poking at the fence. This was documented as the rationale for continued need for the resident's secure placement. The assessment indicated the resident's guardian did not want the resident to return to community living. D. Resident #3's elopement incident on 12/30/24 The facility's investigation, dated 12/31/24, revealed the following information: On 12/31/24 at approximately 11:30 a.m. facility staff discovered that Resident #3 was not in the facility when they went to look for him for the lunch meal. Staff initiated an immediate search for the resident and were not able to locate him on the facility grounds or in the immediate neighborhood. Facility staff called the police for assistance and called the local hospital. At 11:30 a.m., the hospital was able to confirm that Resident #3 was at the hospital and they had assessed him. Resident #3 would not get a ride with the police and left the hospital on foot. Facility staff drove to the hospital and found the resident wandering in an open field. Resident #3 accepted a ride with staff to return to the facility. The investigation revealed that none of the staff on duty on the evening of 12/30/24 could give an accurate account of when Resident #3 was last seen in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Nursing staff had not conducted a monitoring check on the resident at any time on the evening of 12/30/24. The nurse on duty the morning of 12/31/24 documented on Resident #3's December 2024 medication administration record (MAR) that the resident's 6:00 a.m. magnesium and multivitamin tablets were administered. However, it was later discovered through the investigation that the resident was not in the facility at that time. Additionally, staff were not following the care plan to monitor Resident #3's exit-seeking behavior, notice his behavior at the fence looking for weakened fencing areas or monitoring his activity while standing at the fencing. Staff had stopped conducting frequent visual checks of the resident to monitor his location in the facility. It was not until after the resident's elopement that the intervention for frequent visual checks of Resident #3 was added to the resident's care plan. As a part of the facility's investigation, the NHA reviewed video footage of the facility for 24 hours. The video footage revealed Resident #3 had spent the evening of 12/30/24 going in and out of the building, examining the fencing. At one point early in the evening, the resident was observed unscrewing the light bulbs at the far end of the front facility yard. The resident was later seen, at approximately 7:00 p.m,. leaving his room and exiting the door near his room with a packed bag. The resident was then seen on the camera outside, walking the fencing and heading toward the side of the yard where he had spent most of his time that evening and in the location where he had unscrewed the outside light bulbs. The video footage revealed Resident #3 could be seen walking the fencing at 7:00 p.m. until he disappeared off-camera a few minutes later. The resident was not seen back on camera any time after that time. The NHA examined the fence in the area where the resident was last seen and found two holes mid-level in the fencing, one on each side, in the corner where the two pieces of fencing met and the over-hanging wiring had been unscrewed and removed in that section. When interviewed by the NHA upon Resident #3's return to the facility, the resident said he had packed a bag of his belongings and climbed over the fencing with the intention of returning to the city where he previously lived. Resident #3 told the NHA he did not cut the wires on the fence but he did unscrew the wires at the top of the fence and climbed over the fence. Resident #3 said he wanted to get to the city and stay with friends. The NHA asked the resident if he would like a referral sent to other facilities within the desired city's area and the resident agreed but stated he wanted to be able to walk into the community. The NHA explained to Resident #3 the importance of being safe and that the facility would need to contact his guardian to get approval. In conclusion, the investigation report documented that Resident #3 had eloped the facility between 7:00 p. m. and 7:15 p.m. on the evening of 12/30/24 and none of the staff noticed his absence until approximately 16 hours later, on 12/31/24 at approximately 11:00 a.m. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

V. Staff interviews

Resident assistant (RA) #2 was interviewed on 2/25/25 at 1:45 p.m. RA #2 said the staff were conducting 15-minute checks of all residents to make sure residents were present in the facility and the back doors were locked every evening after the last resident smoke break.

Licensed practical nurse (LPN) #1 was interviewed on 2/25/25 at 3:45 p.m. LPN #1 said the nurses were locking the back exit doors every evening after the last resident smoke break at 7:30 p.m. to ensure resident safety and minimize the risk of elopement attempts. LPN #1 demonstrated how the doors were locked. The locking mechanism was observed in practice and verified and the back doors were securely locked after the locking button in the nurse's station was activated.

LPN #1 said facility staff took turns conducting 15-minute head counts to ensure all residents were accounted for. LPN #1 provided the resident head count binder and the resident head count procedure was observed in practice.

Certified nurse aide (CNA) #2 was interviewed on 2/25/25 at 3:50 p.m. CNA #2 provided the resident head count checkbook and said staff from all disciplines took turns rounding and counting all residents to ensure that all residents were accounted for. CNA #2 said if the head count was not accurate, the staff would check the sign-out book to see if a resident was out on a known leave. CNA #2 said if there was no resident on an approved leave, the staff would alert the supervisor on duty and all staff would initiate a search using the census list to find out which resident was missing, while other staff would initiate a search on and off grounds for the missing resident.

RA #1 was interviewed on 2/26/25 at 10:24 a.m. RA #1 said she assisted the CNAs with providing non-direct care resident-related tasks. RA #1 said one of the tasks she performed was monitoring Resident #3 in the dining room to make sure he did not remove silverware from the dining room because he was using it to loosen the fencing so he could elope from the facility. RA #1 said Resident #3 was on 15-minute checks and she had assisted staff in monitoring Resident #3's location since his last elopement in December 2024.

RA #1 said Resident #3 spent most of his time in his room watching television or walking around the front yard pushing on the fencing.

Registered nurse (RN) #2 was interviewed on 2/26/25 at 10:43 a.m. RN #2 said Resident #3 got up early and ate breakfast in the dining room and then spent the early afternoon before lunch wandering the facility's front yard. RN #2 said Resident #3 ate lunch in his room and then resumed wandering the yard but he rarely wandered in the hallways.

RN #2 said Resident #3 had not attempted to elope on the day shift but he did successfully elope one time on the overnight shift. RN #2 said she had seen the resident checking the front fencing, pushing and pulling on the chain links. RN #2 said Resident #3 was hard to talk to but he had told staff that he did not believe that he belonged in the facility.

RN #2 said the facility had a button to lock the back doors where there was no overhanging security fencing at 5:00 p.m. because there was less staff around to monitor that area on the evening and overnight shifts.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065347	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health Care Center, Inc	2120 N 10th St Canon City, CO 81212

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 - Few	RN #3 was interviewed on 2/26/25 at 10:51 a.m. RN #3 said he was aware that Resident #3 had eloped from the facility on 12/30/24 but he did not think that the resident wandered without intention. RN #3 said Resident #3 was on 15-minute checks all day, and staff regularly checked the perimeter fencing for signs of damage that would affect security and elopement prevention. He said the back facility doors were locked starting at 5:00 p.m. every evening. RN #3 said Resident #3 sometimes needed redirection when he was fixated on examining the front fencing but that staff had to also give him space if he became frustrated and agitated with the staff's attention and monitoring. He said staff also had to monitor Resident #3 closely at mealtime to make sure he did not take the silverware out because he would use it to disable the security fencing. CNA #1 was interviewed on 2/26/25 at 10:51 a.m. CNA #1 said she was recently hired and knew who Resident #3 was and had heard about his elopement. She said the resident had not attempted to elope since then. She said Resident #3 wandered outside during the daytime and spent a lot of time in his room. CNA #1 said if Resident #3 eloped from the facility, again staff would initiate a code and initiate an immediate search for the resident. CNA #1 said she had not yet received training on how to respond to a resident elopement. The NHA was interviewed on 2/25/25 at 5:30 p.m. The NHA said she arrived to work on 12/31/24 to find that the staff were unable to locate Resident #3 while conducting rounds to gather residents for the lunch meal. She said while staff initiated a search for the resident, she reviewed video footage of the facility inside and outside. She said she observed the resident on camera going in and out of the facility several times. The NHA said that at approximately 7:00 p.m., Resident #3 was observed leaving his room with a packed bag, going out front towards the security fence and disappearing off camera. She said she checked the fencing where the resident disappeared and discovered there were holes in the fence and the top overhanging security wire was removed. The NHA said staff alerted local police of the resident's absence and called the local hospital and discovered the resident was at the hospital. She said she sent staff to go get the resident and bring him back to the facility. The NHA said the IDT conducted a root cause analysis and found that staff had stopped conducting rounding to check for residents' presence in the facility and the integrity of the fencing was not being monitored. The NHA said following Resident #3's elopement incident, resident rounding had been initiated to ensure all residents were in the facility, the lighting had been replaced so that no one would unscrew the lightbulbs and the camera had been readjusted to give staff a full view of the entire yard. However, the NHA acknowledged that the facility cameras were not being continuously monitored by staff, so staff would not necessarily see a resident climbing over the fence, even with the camera readjustment. (continued on next page)

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(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 - Few	The NHA said the fencing was immediately repaired but it was found to be in poor condition in some areas, so the facility planned to replace the fencing just in the front at this time with a like-new eight-foot fence. The NHA provided the estimate and approval for the like-new eight fence for review. The NHA was not sure when the project would be completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 41032 Based on record review and staff interviews, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. Specifically, the facility failed to develop a facility assessment that included all resources, education, staff competencies and facility based risk assessments for a facility that was a totally secured locked facility for residents with mental illness and dementia diagnosis. Cross-reference F689: failure to prevent a resident from eloping a secured locked facility. Findings include: I. Facility policy and procedure The Facility Assessment policy, dated October 2018, was provided by the nursing home administrator (NHA) on 2/26/25 at 5:26 p.m. It read in pertinent part, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. The facility assessment includes a detailed review of the resident population. The facility assessment also includes a detailed review of the resources available to meet the needs of the resident population. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps determine budget, staffing, training, equipment and supplies needed. It is separate from the quality assurance and performance improvement evaluation. II. Record review The facility assessment was last reviewed on 2/14/25 by the NHA, the director of nursing (DON), the medical director and the governing body and other members of the leadership team. The facility assessment failed to document: -The supplies, equipment and care needed when operating a totally secured locked facility; -The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments; and, (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Include staff training/education necessary to provide the level and types of support and care needed for the resident population needing to reside in a secured locked environment. III. Staff interviews The NHA was interviewed on 2/26/25 at 5:33 p.m. The NHA said the facility assessment was recently updated but she did not remember specifically what was written about the needs of the resident in relation to needing to live in a totally secure facility. The NHA said she would meet with the leadership team and discuss the resident needs and update the facility assessment to reflect more information on providing the resident population a safe and secure environment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 31820 Based on record review and interviews, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under Medicare and Medicaid programs to reasonably ensure residents would be transferred from the facility to a hospital, and assured of timely admission to the hospital when transfer was medically appropriate. Specifically, the facility failed to ensure a written agreement was in effect with one local area hospital. Findings include: I. Record review A request was made to the nursing home administrator (NHA) on 2/26/25 at 2:10 p.m., for the facility's hospital transfer agreement. -The facility was unable to provide a written agreement for the one area hospital. II. Staff interview The NHA was interviewed on 2/27/25 at 2:53 p.m. The NHA said the facility could not locate a hospital transfer agreement. The NHA said she reached out to the local hospital and would get a transfer agreement completed since she could not locate a current agreement. She said it was important to have a hospital transfer agreement in case the facility needed to send a resident out.