STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Villa	1625 Simms St Lakewood, CO 80215

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	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** 43135 Based on observations, interviews, and record review, the facility failed to ensure two (#1 and #2) out of five sample residents at risk for elopement, received adequate supervision and facility assistive devices to prevent elopement. Specifically, the facility failed to provide Resident #1 and Resident #2 the supervision necessary to prevent elopements. These facility failures created a situation with serious harm and a situation with the likelihood of serious harm to residents' health and safety if not immediately corrected. Resident #1, diagnosed with schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), unsteadiness on feet, restlessness and agitation and need for supervision, eloped from the facility on 12/24/23 at approximately 10:11 p.m. when he exited the facility through an alarmed dining room door and an outside gate which was unlocked. Facility staff were unaware Resident #1 was missing until agency certified nurse aide (ACNA) #1 returned to the facility from break at approximately 10:44 p.m. (33 minutes later) and observed the resident seated on the ground in the snow and stuck in an orange construction site fence (a safety barrier, lightweight fence) that separated the facility property from nearby construction. Resident #1 was brought back into the facility by staff and assessed by registered nurse (RN) #1. RN #1 encountered difficulties with obtaining the resident's vital signs and the resident was transported to the hospital for further evaluation shortly thereafter where the resident was diagnosed with right lower extremity frostbite. Resident #1 did not return to the facility per family request. The facility began investigating the incident on 12/27/24 (three days after the resident eloped) and determined Resident #1 eloped from the facility due to the staff's failure to respond to the sound of the dining room door alarm. The facility responded by providing education to the facility staff, beginning on 12/27/24, on resident elopement and what to do in the event a door alarm went off. The facility created a binder for all agency staff to read before their shift to learn what to do in the event a door alarm went off. The facility began monitoring the elopement interventions in the quality assurance and performance improvement (QAPI) meetings beginning on 1/11/24 and planned to monitor the process for three months or longer as needed. (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 - Few	The education regarding elopement interventions and responding to door alarms proved to be ineffective as another resident elopement occurred on 2/2/24. Resident #2, diagnosed with paranoid schizophrenia (a mental disorder characterized by recurrent episodes of psychosis that are correlated with a general misperception of reality) and dementia, eloped from the facility on 2/2/24 at 9:48 p.m. when he exited the facility through the same alarmed dining room door and unlocked outside gate. At 10:20 p.m. (32 minutes later) the local police department called the facility to ask if the facility was missing a resident. Facility staff did a search of all residents and discovered Resident #2 was missing from the facility. At 10:30 p.m. the facility nurse called the police back and informed them Resident #2 was missing. The police informed the facility Resident #2 was found at a busy intersection approximately one tenth of a mile from the facility and had been taken to a local hospital for an evaluation. Resident #2 returned to the facility from the hospital on 2/3/24 at 1:25 a.m. with no noted injuries. Findings include: Observations, interviews, and record review confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/25/24 to 5/1/24, resulting in the deficiency being cited as past noncompliance with a correction date of 2/7/24. I. Situation of serious harm The facility failed to ensure facility staff were aware of the proper procedures to respond timely to door alarms and how to reset the alarm for a door once an alarm had been triggered. This resulted in Resident #1 eloping from the facility on 12/24/23 and sustaining frostbite to his right lower extremity. Following the elopement incident with Resident #1 on 12/24/23, the facility failed to put effective interventions and systems into place to ensure further resident elopements did not occur. This resulted in Resident #2 eloping from the facility on 2/2/24 and being found by the local police department at a busy intersection approximately one tenth of a mile from the facility and taken to a local hospital for an evaluation. II. Facility plan of correction The corrective action plan the facility implemented in response to Resident #2's elopement incident on 2/2/24 was provided by the nursing home administrator (NHA) on 4/25/24 at 2:00 p.m. A. Immediate action Resident #2's care plan was updated on 2/5/24 to include the following interventions: -Provide activities to attempt giving the resident meaningful activities; -Facility to add a chirping alarm to dining room doors; and, -Nursing to conduct frequent checks for resident's whereabouts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. Identification of others affected The facility determined, due to the facility's population of residents with dementia, every resident was at risk for eloping from the facility. C. Systemic changes -On 2/3/24 the facility ordered new door alarms. The new alarm system had no automatic shut off and the alarm continued to sound until it was turned off by the facility staff and rearmed with a key. -On 2/3/24 the facility ordered items to rebuild the entire egress area (where the outside gate was opened). The ordered items included black aluminum fence panels, fast setting concrete mix, a new gate door, door hardware for installation, and a battery operated powered door mounted weatherized exit alarm. -On 2/3/24 facility staff were educated on how to turn the current alarms off until the new door alarms were installed. -On 2/3/24 the staffing agency was notified via text of the elopement binder with directions of how to turn the current alarms off which was to be read by all agency staff before each person worked in the facility. -On 2/5/24 visual aide note cards were added to the doors about how the keys were to turn to reset the alarms on the doors. -On 2/7/24 the new door alarms were installed and staff education of how to work the alarms began. -On 2/7/24, weekly documentation of safety checks on the door alarms was started by the plant operations director (POD). -On 2/29/24, the outside gate improvement project was completed. Weekly checks of the outside gate area were started. -On 2/7/24 the new door alarm system was installed which removed the immediacy of the deficient practice. The outdoor gate improvement project, which was completed on 12/29/24, was an additional security measure put in place by the facility, however, it was not the main security issue, therefore the correction date for the deficient practice was 2/7/24. D. Monitoring The facility would monitor the elopement situation and the weekly safety check documentation in the monthly QAPI meetings. Observations, interviews and record review during the complaint investigation from 4/25/24 to 5/1/24 revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	III. Facility Policy and procedures The Elopement Management System policy, March 2023, was provided by the NHA on 4/25/24 at 2:50 p.m. It revealed in pertinent part, Each resident is assisted in attaining/maintaining his or her highest practicable level of function by providing the resident with adequate supervision, activity/functional programs as appropriate and safety interventions to minimize elopement risk. Signaling devices may be used, if available, and determined to be an appropriate intervention. The Interdisciplinary Team (IDT) evaluates each resident to identify elopement risk. A Care Plan is developed and implemented based on this evaluation, with ongoing review. The Administrator and Director of Nursing are responsible for coordination of an interdisciplinary approach to managing the process for prediction, risk assessment, treatment, evaluation, and monitoring of exit-seeking behavior. Unsafe Wandering or Elopement According to the Centers for Medicare & Medicaid Services,Wandering is random or repetitive locomotion. This movement may be goal-directed (the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the center aimlessly may indicate that the resident is frustrated, anxious, bored, hungry, or depressed. Unsafe wandering and elopement may be associated with falls and related injuries. Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards (chemicals, tools and equipment). While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. The Maintenance Director or designee will complete preventive maintenance for door monitor testing, door range testing, function tester maintenance and elopement drills. Care Plan interventions are individualized to the resident and are based on the assessed risk of elopement. IV. Resident #1 A. Resident status Resident #1, age over 75, was admitted on [DATE] and readmitted on [DATE]. According to the October 2023 computerized physician orders (CPO), diagnoses included schizoaffective disorder, cerebral infarction (stroke), unsteadiness on feet, adult failure to thrive, vascular dementia, hypertension (high blood pressure), need for continuous supervision and restlessness and agitation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 10/17/23 minimum data set (MDS) assessment revealed the resident had severely impaired cognitive skills for daily decision-making and had disorganized thinking. He required maximum assistance with toileting, showering, upper and lower body dressing, and putting on and off footwear. He was always incontinent of bowel and bladder. He used a wheelchair. He needed supervision or touch assistance to walk 150 ft. (feet). B. Record review The comprehensive care plan initiated, on 10/16/23 and revised on 11/3/23, revealed Resident #1 was at a high risk for falls related to confusion, gait and balance problems, poor communication and comprehension. The resident was unaware of safety needs and wandered. Pertinent interventions included anticipating and meeting the resident's needs, ensuring the resident's call light was within reach and encouraging the resident to use it for assistance as needed and responding promptly to all of the resident's requests for assistance. The elopement evaluation, dated 12/25/23 revealed the resident ambulated with or without the use of an assistive device or wheelchair. The resident had a history of elopement or attempted elopement while at home. The resident had a history of elopement or attempted to leave the facility without informing staff. The resident had expressed a desire to go home, packed belongings to go home or stayed near an exit door. The resident wandered and his wandering was likely to affect the safety of himself or others. The nursing progress note related to the elopement incident on 12/24/23, documented on 12/25/23 by RN #1 revealed RN #1 piled blankets on Resident #1 when he was brought back into the facility and RN #1 called 911. Resident #1 was shaking vehemently and RN #1 was unable to get a temperature or pulse oximeter (to read the oxygen levels in the body) for the resident. The resident's feet and hands had deep erythema (reddening of the skin) to his fingers and toes with a waxy appearance. A hospital progress note, dated 12/24/23 revealed the diagnoses of hypothermia and an altered mental status. On 12/25/23 the hospital documented Resident #1 complained of pain to his toes as they rewarmed. Emergency medical services (EMS) noted the resident was cold with a temperature of 88 degrees Fahrenheit. A nursing progress note dated 12/27/23 revealed a nurse from the facility called the hospital where Resident #1 was staying. The hospital told the facility's nurse Resident #1 was in stable condition and had right lower extremity frostbite. C. Review of the 12/24/23 incident On 4/25/24 at 2:00 p.m. the NHA provided the investigation of Resident #1's elopement on 12/24/23. The investigation revealed the following: Resident #1 was seen on the facility's video recording on 12/24/23 at 10:04 p.m. walking around the dining room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 10:11 p.m. Resident #1 was observed on camera standing in front of the dining room door that led to the outside. The video camera did not record for approximately 1-2 minutes due to connection issues. When the camera turned back on the view was of a closed door, however, Resident #1 was no longer observed on the video. The facility documented Resident #1 went out the dining room door during the video outage and then out the unsecured gate where there was no video coverage. At 10:44 p.m. the camera revealed RN #1 at the front door of the facility talking to a staff member. The agency certified nurse aide (ACNA) #1 said he drove his car to a convenience store nearby and returned from his lunch break around 10:44 p.m. ACNA #1 said he saw a person seated on the ground in the snow who was stuck in an orange construction site fence, a barrier, safety, lightweight fence that separated the facility property from nearby construction. ACNA #1 walked up to the person who was seated on the ground but was unsure if it was one of the residents or a homeless person. ACNA #1 said the area had frequently spotted homeless individuals in the area. ACNA #1 went in the facility to get RN #1 and ACNA #2. RN #1 verified it was one of the facility residents and the two ACNA's used a wheelchair to bring the resident back into the facility. RN #1 documented difficulty obtaining vitals on Resident #1 and RN #1 called for an ambulance to take Resident #1 to the hospital. Resident #1 went to the hospital and did not return to the facility per the family's request. On 12/27/24 (three days after the incident) the facility began investigating the incident. The facility was unable to determine whether the outside gate, which had a code, was left open by the facility staff or was damaged by the homeless individuals who were often seen in the nearby field. The facility investigation determined the agency staff in the building did not recognize the chirping sounds from the alarm to be a warning sound of a door opening. The alarm sound was determined to stop sounding after 90 seconds. Following the 90 seconds, the door did not reset the alarm unless a key was manually used to reset it. On 12/27/24 education was provided to the facility staff and the facility made a binder for all agency staff to read before their shifts to learn what to do in the event a door alarm went off. The facility began monitoring the occurrence in the QAPI meetings on 1/11/24 and planned to monitor for three months or longer as needed. D. Staff interviews The NHA was interviewed on 4/25/24 at 2:15 p.m. The NHA said, on 12/27/23, she began training all facility staff on alarming the doors and locking the gate. She said on 12/27/23 she began an elopement book of procedures that she required all agency staff to read before they began a shift in the facility. She said she began monitoring the situation through the QAPI meeting process.The NHA said RN #1 no longer worked at 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	ACNA #1 was interviewed on 4/29/24 at 4:35 p.m. ACNA #1 said, on 12/24/23, he was the one who found Resident #1 in the field. ACNA #1 said he drove his car to get something to eat around 10:10 p.m. and when he returned around 10:40 p.m. he saw someone in the field next to the facility. He said he approached the man to check if it was a resident or one of the homeless people in the area. He said the man was seated in the snow on his posterior and his legs and hands were stuck in the construction fence. He said he thought it was a resident so he went inside and got the nurse to come outside with him to evaluate the situation. ACNA #1 said RN #1 and ACNA #2 came outside with a wheelchair. He said he and ACNA #2 put Resident #1 in a wheelchair and brought the resident back inside the facility. He said Resident #1 was too cold to get vital signs so RN #1 called 911. He said EMS came shortly after the call and took Resident #1 to the hospital. ACNA #1 said after Resident #1 was safely back inside, he and ACNA #2 checked the alarms on the doors. ACNA #1 said the alarm on the door the resident seemed to have gone out did not sound and the gate outside was opened. He said he reset the alarm when it was discovered it was not on. He said he did not know how long the alarm had been off. ACNA #2 was interviewed on 4/29/24 at 4:56 p.m. ACNA #2 said, on 12/24/23 around 10:40 p.m., he received a text from ACNA #1 to come outside and give him help. He said he brought a wheelchair outside and he and ACNA #1 put Resident #1 in the wheelchair and brought him back into the facility. He said he did not hear an alarm go off that night. He said he and ACNA #1 tried to figure out how Resident #1 got outside of the building. He said ACNA #1 reset the alarms on the door after Resident #1 went to the hospital. -RN #1 was contacted for an interview on 4/29/24 at 5:14 p.m, however, an interview was unable to be conducted. V. Resident #2 A. Resident status Resident #2, age under 75, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included paranoid schizophrenia, unsteadiness on his feet, hypertension (high blood pressure), dementia with behavioral disturbances, history of falls and shortness of breath. The 11/16/23 MDS assessment revealed the resident had short and long term memory problems, continued inattention and disorganized thinking. He had behavioral symptoms occasionally directed at others, kicking, biting, hitting, pushing, scratching or grabbing. He had impaired vision. B. Record review The comprehensive care plan, initiated on 11/21/22 and revised on 12/1/23, revealed Resident #2 was an elopement risk/wanderer with a history of attempts to leave a previous facility he lived in. Due to the resident's progressing dementia, Resident #2 had been determined to be in need of a secured unit facility. Resident #2 had aggressive behaviors related to exit seeking and was not redirectable. Pertinent interventions included identifying the resident's patterns of wandering, nursing to conduct frequent checks for the resident's whereabouts and de-escalating the resident's behaviors through redirection. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The comprehensive care plan further revealed the resident had a history of pressing on doors to set off the alarm on them. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. The elopement evaluation, dated 6/20/23, revealed the resident was able to ambulate without the use of assistive devices or a wheelchair. He had a history of elopement. He had a history of trying to leave the facility without informing the staff. He verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. The resident wandered and it was likely to affect his safety or the safety of others. A hospital progress note, dated after the elopement on 2/2/24, revealed the resident was found wandering in the middle of an intersection by the police and brought to the emergency room . The hospital found the resident to be safe and able to return to the nursing home. A nursing progress note related to the 2/2/24 elopement, documented on 2/3/24, revealed the police called the facility at 10:20 p.m. on 2/2/24 and said Resident #2 was found wandering alone on the street. At 10:30 p. m. the nurse called the police back and answered their questions. On 2/3/24 at 1:25 a.m. Resident #2 returned to the facility on a stretcher from the hospital. C. Review of the 2/2/24 incident On 4/25/24 at 2:00 p.m. the NHA provided the investigation of Resident #2's elopement on 2/2/24. The investigation revealed the following: On 2/2/24 at 9:48 p.m. Resident #2 was seen leaving out the same dining room door that Resident #1 went out at 9:48 p.m. on 12/24/23. At 10:20 p.m. the local police department called the facility to ask if the facility was missing a resident. Facility staff were not sure if any residents were missing and said they would look and call the police back. Facility staff did a search of all residents and discovered Resident #2 was missing from the facility. At 10:30 p.m. the facility nurse called the police back and informed them Resident #2 was missing. The police informed the facility Resident #2 was found at a busy intersection approximately one tenth of a mile from the facility and had been taken to a local hospital for an evaluation. Resident #2 returned to the facility from the hospital on 2/3/24 at 1:25 a.m. with no noted injuries. Resident #2 was unable to be interviewed due to cognitive impairment. Resident #2 had a legal representative who was notified of the incident. On 2/3/24 the NHA's investigation revealed the dining room door to the outside had an alarm that did not go off and sound. Staff said they were not in the area of the dining room and did not hear the alarm sound. Again the outside gate was unlocked and it was not determined if a staff person did not lock the gate or a homeless person from the nearby areas opened the gate. D. Staff interviews (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was interviewed on 4/25/24 at 2:15 p.m. The NHA said after Resident #2 was the second resident to elope from the facility, she determined the alarm system needed to be replaced and more education needed to be provided to the facility staff as well as any agency staff that worked in the building. She said the building had ongoing agency staff working in the building. She said she called the agency where the staff came from and informed them that all agency staff who came to work at the facility had to read the policy of elopement and what the process was to keep the door alarms on. The regional director of plant operations (RDPO) was interviewed on 4/25/24 at 2:53 p.m. over the phone. The RDPO said he came in a day or two after the 12/25/23 elopement incident to evaluate what had happened with the alarm system and the outside gate lock. The RDPO said after the first elopement investigation, it seemed possible that a staff person did not reset the alarm prior to Resident #1 leaving the facility. He said the alarm shut off in 90 seconds and needed a key to turn the alarm back on. He said it seemed, through education of the staff, the situation would be fixed. The RDPO said the second time there was an elopement, on 2/2/24, he came in the next day. He said he determined, along with the NHA, that a new alarm system needed to be installed. He said the outside gate also needed to have something new installed. He said new alarms were installed on the dining room door where the residents eloped from. The RDPO said it was determined that a security camera needed to be installed in the back gate area. He said he contacted (name of approving agency) to get approval to redesign and install a new egress area between the dining room door and the gate. He said the parts for the door alarm were ordered and put up around 2/7/24. The RDPO said as soon as he had approval, the egress area parts were ordered, and the installation took a few days. He said the egress was completed sometime at the end of February 2024. The RDPO said he and the NHA looked at everything after the first elopement and they thought education to the staff was the solution but it was not good enough. He said after the second elopement, he designed an entirely new solution. The RDPO said the second solution worked because no residents had eloped since the new system was put in place. CNA #3 was interviewed on 4/30/24 at 10:01 a.m. CNA #3 said she was working in the front part of the facility on the night Resident #2 eloped. She said the nurse on duty told her the police called to ask if the facility was missing a resident. CNA #3 said the staff began a head count of the residents and discovered Resident #2 was not in the facility. CNA #3 said staff checked the dining room door and the alarm was disarmed and the gate door was opened in the egress section. CNA #3 said she did not know who disarmed the alarm or when it happened. She said the staff did not know Resident #2 was gone out of the facility until the police called to tell them. Agency registered nurse (ARN) #1 was interviewed on 4/30/24 at 10:45 a.m. ARN #1 said he was told by his staffing agency to read the binder in the facility before he worked and then sign that he acknowledged what he read. He said the binder contained instructions on how to respond when the alarms sounded. He said he could hear the alarms clearly in the halls and resident rooms. He said the alarms took a key to shut off the alarm and reset the alarm. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #2 and CNA #3 were interviewed on 4/30/24 at 11:20 a.m. Both CNAs said they never entered for work through the gate where the residents eloped. Both CNAs said when a resident pushed on a door, an alarm sounded that was loud enough for them to hear wherever they were working in the building. Both CNAs said the alarm continued to sound until someone came with the key to turn the alarm off and reset the alarm. The NHA was interviewed again on 5/1/24 at 10:00 a.m. The NHA provided documentation of the QAPI process. She said all facility management, the pharmacist, and the medical director attended the QAPI meeting. The NHA said after the incident on 12/24/23 a review at QAPI began immediately in January 2024. She said the QAPI committee met one time per month. The NHA said she had hoped the review would be completed within three months after the 12/24/23 incident but it was not done in three months because of the 2/2/24 elopement. The NHA said the elopement situation would be reviewed in QAPI for at least three months, through May 2024 or longer if the situation needed more review. The NHA said the alarms and gates would be monitored weekly indefinitely.