

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06A185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER Southeast Colorado Hospital Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 373 E 10th Ave Springfield, CO 81073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>Based on record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#1) of three residents reviewed for accidents out of three sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #1 had an individualized care plan with person-centered interventions to prevent elopement; and, -Ensure Resident #1 was provided with the supervision necessary to prevent an elopement. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Elopement and Wandering policy and procedure, revised June 2019, was provided by the nursing home administrator (NHA) on 4/22/25 at 3:05 p.m. It read in pertinent part, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.</p> <p>Procedure:</p> <ul style="list-style-type: none"> -Staff will identify residents who are risk for harm because of unsafe wandering; -Staff will assess at-risk residents for potentially correctable risk factors related to unsafe wandering; -The resident's care plan will indicate the resident is at risk for elopement; -Interventions to maintain safety will be included in residents' care plans; -Staff will document circumstances related to unsafe actions, including wandering by a resident; <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff will institute a monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior;</p> <p>-A Potential Elopement Risk Assessment will be completed for the resident;</p> <p>-If a resident residing in the long-term care side of the building is at risk of leaving the facility the resident will be taken to the Alzheimer's unit for safety; and,</p> <p>-Staff will notify the administrator and director of nursing (DON) immediately and will institute appropriate measures for any resident who is discovered to be missing from the unit or facility.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included traumatic brain injury, post-traumatic headache, diabetes and hypertension.</p> <p>The 10/15/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He was independent with activities of daily living (ADL) but required supervision/touching assistance from staff for ambulation and he used a walker.</p> <p>According to the assessment, Resident #1 had no history of wandering.</p> <p>B. Record review</p> <p>Review of Resident #1's electronic medical record (EMR) revealed the following progress notes:</p> <p>The 1/15/25 at 2:07 a.m. nurse progress note revealed Resident #1 was up all night wandering the facility.</p> <p>The 1/15/25 at 1:25 p.m. nurse progress note revealed Resident #1 was increasingly restless at night and wandered from room to room, to the solarium and back to bed. This was routine for him throughout the night.</p> <p>The 1/16/25 at 3:10 p.m. nurse progress note revealed Resident #1 was increasingly restless at night and wandered from room to room, to the solarium and back to bed. This was routine for him throughout the night.</p> <p>The 1/19/25 3:24 a.m. nurse progress note revealed Resident #1 was increasingly restless at night and wandered from room to room, to the solarium and back to bed. This was routine for him throughout the night.</p> <p>The 1/20/25 7:03 a.m. nurse progress note revealed Resident #1 was increasingly restless at night and wandered from room to room, to the solarium and back to bed. This was routine for him throughout the night.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 3/30/25 nurse progress note revealed Resident #1 was found outside of the facility, several blocks away, by a woman who called the facility at 4:50 p.m. and stated Resident #1 was observed near a residential home in town. A staff member left the facility to pick up Resident #1. Upon return to the facility, Resident #1 reported he did not remember where he was going.</p> <p>When Resident #1 returned to the facility the staff placed Resident #1 on 15-minute safety checks.</p> <p>-However, the facility failed to initiate a care plan focus and person-centered interventions for wandering or elopement to prevent further elopements for Resident #1 (see care plan below).</p> <p>-Review of Resident #1's EMR failed to reveal the facility conducted an elopement risk assessment when Resident #1 returned to the facility on [DATE].</p> <p>The 3/31/25 at 6:40 a.m. nurse progress note revealed Resident #1 had been wandering the unit all night and trying to go outside using any of the exit doors. Staff redirected Resident #1 to his room.</p> <p>The 3/31/25 at 2:59 p.m. nurse progress note revealed Resident #1 wandered around the unit and was caught at 11:50 a.m. by the nurse as he exited the front doors.</p> <p>The 3/31/25 at 4:50 p.m. social services director's (SSD) progress note revealed Resident #1 was found on 3/30/25 at a random house in the community and was seated with the people that lived in the house. The note documented the resident did not remember where he was going. The SSD note documented that maybe the resident left the facility because it was nice outside and the social worker had no concerns that he wanted to elope.</p> <p>-However, the facility again failed to initiate a care plan focus and person-centered interventions for wandering or elopement to prevent further elopements for Resident #1 after he continued to wander and attempt to get outside through the exit doors on 3/31/25 (see care plan below).</p> <p>The 3/31/25 at 5:44 p.m. nurse progress note revealed Resident #1 continued to wander around the facility looking for his ride and looking to leave. The resident was overwhelmed from the constant wandering and was placed in the locked care secure unit.</p> <p>An elopement risk care plan was initiated on 4/1/25 by the director of nursing (DON). Interventions included ensuring the resident was in a safe and comfortable environment, structuring the residents' day to monitor activities and safety, providing regular hydration, snacks, toileting and pain management, performing frequent location checks if the resident was exhibiting exit seeking behavior, moving the resident to a controlled access unit (dementia unit), assessing the resident for any emotions that would trigger the resident wanting to leave and encouraging life engagement activities that the resident enjoyed.</p> <p>-Despite Resident #1 exhibiting wandering behaviors and the potential for elopement, the facility failed to initiate a care plan focus for the resident's wandering behaviors and elopement risk until 4/1/25, two days after the resident eloped from the facility and was found at a home in the community several blocks away from the facility on 3/30/25.</p> <p>III. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 4/22/25 at 1:47 p.m. The DON said residents were screened for wandering behaviors and elopement risk prior to admission. The DON said if a resident was at high risk for elopement, the resident was assigned to a room on the locked secure unit for safety. The DON said Resident #1 had no history of wandering or elopement attempts prior to 3/30/25.</p> <p>-However, progress notes in January 2025 documented the resident was wandering at night throughout the facility (see record review above).</p> <p>The DON said the SSD was responsible for completing the elopement risk assessment on residents after admission to the facility. The DON said the facility's exit doors were unsecured and not always monitored by staff. She said residents in the facility were able to enter and exit without staff assistance. The DON said when Resident #1 returned to the facility on [DATE], the nurse assessed the resident but did not notify the NHA, the DON or the physician of the resident's elopement from the facility.</p> <p>The SSD was interviewed on 4/22/25 at 3:15 p.m. The SSD said she completed an elopement risk assessment on residents when she was notified by staff to complete the assessment. She said she was notified by staff on 3/31/25 about Resident #1's elopement on 3/30/25, which prompted her to complete an elopement risk assessment.</p> <p>After reviewing the nurse progress notes, dated 1/15/25, 1/16/25, 1/19/25 and 1/20/25, the SSD said she was unaware Resident #1 had wandering behaviors before 3/30/25. She said wandering from room to room was not concerning because Resident #1 was walking around inside the facility during the night and it was not exit-seeking behavior. The SSD said the wandering behavior to the exit doors was a sudden change for the resident. She said Resident #1 wanted to be outdoors with the nice weather changes. The SSD said Resident #1 was reassigned and moved to a room in the locked secure unit on 4/1/25. She said Resident #1 had had no additional elopement attempts.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 4/22/25 at 4:10 p.m. LPN #1 said she was familiar with Resident #1 and said he had wandering behaviors during the night. She said the unit where Resident #1 resided before he eloped was not a secure unit. LPN #1 said when residents wandered, staff watched the residents to anticipate their needs and ensure their safety. LPN #1 said the exit doors were not monitored and Resident #1 was able to exit the facility when he was unsupervised by staff before he was moved to the locked secure unit on 4/1/25.</p> <p>The NHA was interviewed on 4/3/25 at 5:15 p.m. The NHA said she was unaware of Resident #1's wandering behaviors before he eloped on 3/30/25. The NHA said the facility would review the facility's wandering and elopement risk assessment process and ensure residents were screened at the time of admission and as needed if a resident had wandering behavior.</p>		