STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure the interdisciplinary team (IDT) assessed one (#2) of one resident for the capability to safely self-administer medications out of seven sample residents. Specifically, the facility failed to assess Resident #2 for safety of administering medications independently. Cross-reference to F657, (failure to review and revise a comprehensive care plan after resident was assessed to self-administer medications). Findings include: A. Resident status Resident #2, age 58, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 7/29/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance of two and more people with activities of daily living. B. Resident interview and observation Resident #2 was interviewed on 9/15/2020 around 3:20 p.m. Resident was in bed on her right side facing the door. She said she does not trust nurses with her medications and all her medications are kept in her room in a locked box at the table next to her. She said she is the only person who has access to the box and she independently took her medications for at least a month. Resident said she had in her possession [MEDICATION NAME], aspirin, [MEDICATION NAME], an [MEDICATION NAME] inhaler and vitamin D. She said she was able to administer all these medications independently. She said no one educated her on the proper use of medications as she had taken it for a long time and she knew how to do it. She said she always kept it at the bedside as it was a convenient place for her to access them. She said she did not talk to the doctor or nurse practitioner about her medications. C. Record review. 1. Failure to assess the resident by an interdisciplinary team (IDT) in order to determine whenever the self-administration of medications was clinically appropriate. The most recent self-administration assessment was dated 7/7/2020 and read: Resident would like her medications to be kept in a locked cabinet in her room and administered by the nurse. According to active CPO ' s, the most current self-administration order by physician was dated 4/10/2020 and read: May leave all meds at bedside, please recheck with resident that all medications were taken. -There was no additional self-administration assessment to show that the resident was able to self administer all of her medications as it was mentioned in her care plan and physician 's order. The care plan for self-administration of medications, initiated 2/12/2020 and revised 5/1/2020, identified the resident was able to self-administer all of her medications. Interventions included to evaluate resident quarterly and as needed, monitor for proper storage and usage of medications. -The care plan was not updated on 7/7/2020 when the resident was re-evaluated for self-administration in the presence of the nurse. Upon review of the resident 's medical records no documentation was revealed that an interdisciplinary team (IDT) was involved in determining whenever the self-administration of medications was clinically appropriate. 2. Failure to have a current physician 's order for the self-administration of all medications that resident had in her lock box. According to active CPO ' s, the most current self-administration order was dated 4/10/2020 and read: May leave all meds at bedside, please recheck with resident that all medications were taken. Review of September 2020 medical administration records (MARs) and treatment administration records (TARs) revealed the resident received the following medications, and not all of them were marked that resident could self-administer them. -[MEDICATION NAME] Diskus, one puff inhale orally two times a day related to asthma, unsupervised self-administration rinse and spit after use. May keep at bedside. -Aspirin Tablet 81 milligram (mg) one tablet by mouth at bedtime for cardioprotection. Do not give at the same with [MEDICATION NAME]. -[MEDICATION NAME] Capsule 300 mg by mouth two times a day for chronic pain, unsupervised self-administration. May self-administer and keep at bedside in lockbox. -[MEDICATION NAME] 800 mg one tablet by mouth two times a day for chronic pain, unsupervised self-administration. May self-administer and keep at bedside in lockbox. -[MEDICATION NAME] Tablet Extended Release 600 mg by mouth in the morning. Unsupervised self-administration. May self-administer and keep at her bedside in the lockbox. -Vitamin D3 Tablet ([MEDICATION NAME]) Give units by mouth in the morning every four weeks on Thursdays for health supplement. There was no documentation by nurses to show that they checked with the resident if she took her medications or not. D.Staff interviews The nurse practitioner (NP) was interviewed on 9/15/2020 at 3:00 p.m. He said he recalled having a conversation with Resident #2 regarding self-administration of her medications. He said Resident #2 was determined capable of administering her own medications. He said he gave an order to nursing staff some time after 7/7/2020 to allow the resident to self-administer all of her medications. Licensed practical nurse (LPN) #1 was interviewed on 9/16/2020 around 11:30 a.m. She said she frequently worked with resident and was a full time nurse on the unit where Resident #2 resided. She said Resident #2 did not like her and did not want her in her room, she said every time I walked in her room she cursed and told me to get out. LPN#1 said she was not able to assess what medications the resident took because Resident #2 refused to talk to her. She said the director of nursing (DON) and other staff members were aware that the resident disliked many staff members and was not cooperative with care. Registered nurse (RN) #1 was interviewed on 9/17/2020 around 2:00 p.m. She said the resident was particular about her care and oftentimes verbally abusive and inappropriate. She said the resident had an order for [REDACTED].#2 would not show. She said she would ask the resident if she took her medications, but she did not document that anywhere. RN #1 reviewed most current physician orders [REDACTED]. She reviewed the most recent self-administration assessment dated [DATE] and said it was also inaccurate because the assessment read that medications should be administered by a nurse. She said the resident was self-administering medications independently. RN #1 said she will contact the physician for clarification and discuss it with DON. The DON was interviewed on 9/17/2020 at 2:15 p.m. She said Resident #2 had a physician 's order for self-administration of medications since 4/10/2020. She said she could not locate the IDT assessment that was completed by facility on 7/7/2020 determining whenever the self-administration of medications was clinically appropriate. She said nurses were supposed to check with the resident every shift and document if medications were taken. She said she was aware the resident had abusive behaviors and was selective with staff members but she did not know the resident refused to talk to nurses about medications that she took. She said the self-administration assessment on 7/7/2020 was not accurate as it read that all medications should be administered by the nurse, and provided an assessment that was dated 9/16/2020 (last day of the survey). The assessment revealed Resident#2 was no longer able to self-administer medications due to the lack of cooperation with the nursing staff.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure one (#1) out of three discharged residents out of seven sample residents received appropriate notification of the discharge and was provided a safe discharge.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Specifically, the facility failed to show the resident's responsible party was initially notified of the resident's behavior leading up to and including the transfer to the local acute hospital on an M1 hold (emergency mental health hold procedure, which allows for a person to be involuntarily held for a 72-hour period of treatment and evaluation if he or she appears to have a mental illness and, due to the mental illness, appears to be an imminent danger to self or others, or appears to be gravely disabled). I. Facility policy and procedures A. The Transfer and Discharge policy, dated November 2017, was provided by the nursing home administrator (NHA) via email on 9/17/2020 at 2:45 p.m. The policy read in pertinent part, The facility assists with preparation and orientation of the resident to ensure safe and orderly transfer or discharge from the facility. Preparation and orientation included: -Informing the resident where he or she is going; -Taking steps to assure safe transportation; -Involving the resident and/or the resident's representative in selecting the new residence; -Working with family to assure that the resident's possessions transfer with the resident; -Reviewing with staff the routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression; -Making appropriate referrals; and -Providing counseling, if necessary. The policy documented,Nursing staff completes the Resident Transfer form (Electronic Health Record) if the resident is transferring to an acute health care facility or another nursing facility. The information provided to the receiving provider must include at minimum: -Contact information of the practitioner responsible for the care of the resident; -Resident representative's contact information; -Advance Directive information; -All special instructions or precautions for ongoing care, as appropriate; -Comprehensive care plan goals; -A copy of the Physician Discharge Summary; and -All other necessary information or documentation to ensure a safe and effective transition of care. B. The Involuntary Discharge policy was provided by the NHA via email on 9/17/2020 at 2:45 p.m. The section titled, Discharge for Failure to Meet Needs, Nursing Care No Longer Required, and Danger to Self or Other Residents read in pertinent part, Before a facility initiates the involuntary discharge process, the facility assures it has taken all necessary steps to address the clinical circumstances that are the basis for the involuntary discharge. The resident's legal representative(s) are contacted to discuss the resident's clinical and psychosocial needs and to help determine whether alternative placement is recommended for the resident. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident did not participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. B. Record review 1. Care plan The discharge care plan initiated 3/20/2018 and revised 1/23/2019 documented the resident wished to reside at the facility long term and discharge planning was in process for a male, secured, long term care bed due to sexually inappropriate behaviors. The goal, revised on 6/28/2020 with a target date of 9/21/2020 read, the resident's preference to stay at the facility long term will be honored. Interventions initiated 3/20/2018 and revised 1/23/2019 included to continue to monitor for sexually inappropriate behaviors. Intervene as necessary to keep other residents safe; Establish a care plan with resident/family/caregivers and evaluate progress and revise plan quarterly and PRN (as needed); Keep resident and POA (power of attorney) informed on discharge planning; and referrals have been sent to male secured units. 2. Progress notes a. Behavior progress Reviewed notes from 7/7/2020 through 8/15/2020 Progress notes indicated an increase in dementia related symptoms of delusions, aggression, memory and mood problems. The resident exhibited behaviors of increased smoking, delusions, verbal and physical aggression, and elopement from the facility. The resident was transferred to the local hospital on [DATE] on an M1 hold (a psychological hold at hospital). A behavior progress note dated 7/7/2020 at 10:57 a.m. documented social services (SS) offered the resident a smoking holder to hold his cigarettes. SS had also explained what it was and why it was offered to him. The nurse wrote, Resident wasn't quite happy about using it and said I don't need a cigarette holder, I used to hold the cigarettes when I smoked, he was disappointed to use it. The smoker holder was kept safe on the nurses cart and offered to him every episode. On 7/7/2020 at 1:02 p.m. a behavior progress note documented the resident was aggressive when not getting a cigarette frequently. According to smoking regulations, he was able to have a cigarette every 2-3 (two to three) hours, The nurse wrote the resident asked frequently for cigarettes and if it was not received, he became agitated and shouted at the nurse. The nurse documented the resident walking away from the nurses station unhappy and after five minutes he returned to the nurses station and received a cigarette. On 7/7/2020 at 8:54 p.m. a behavior progress note documented the Resident kept asking for a cigarette every 20 minutes. When the nurse told the resident it was too early and that he was given a cigarette 20 minutes ago, the resident got really upset and started to yell saying that the nurse is not being fair. Resident forgets when he smokes and keeps coming back asking for more cigarettes every 20 minutes. A behavior progress note dated 7/18/2020 revealed the resident became agitated and aggressive when he has not received his cigarettes. He asked frequently (for cigarettes) even if he received one 10 minutes before. The note documented his cigarettes ran out on 7/18/2020. He became mad and was verbally as well as physically aggressive and wanted to leave the building. The nurse wrote, Every time is hard for him to handle the situations. We can keep our distance from him. He is also mean to other helping staff. A behavior progress note dated 7/19/2020 documented the resident became agitated and combative when asking for a cigarette. The nurse wrote, We cooperate with him by providing cigarettes every hour. Other residents also complained about his latest behavior. His behavior has changed day by day. He wanted to discharge somewhere. A behavior progress note dated 7/21/2020 read, approximately 8:00 p.m., the resident walked out of his room without the walker. When the nurse advised the resident to use a walker for safety, the resident yelled at the nurse stating I can walk without the (expletive) walker. The resident walked past the dining hall and sat in the front room. When the nurse opened the front door to let the X-ray vendor out, the resident pushed and hit the nurse. When staff tried to stop him he forced himself out the door. After a couple minutes, the nurse and CNA (certified nurse aide) were able to convince him to come in. Resident is very agitated regarding cigarettes. Since the resident is getting too aggressive, this nurse gave half a packet of cigarettes to the resident. A behavior progress note dated 7/29/2020 documented the resident was not compliant with cigarette storage. At 3:00 p.m., the resident dropped the empty cigarette storage case at the nurses desk. When this nurse ask resident what was wrong, resident stated this is stupid and I took all the cigarettes out. Since then, the resident has been asking for a cigarette every 15 minutes. When the nurse explained to the resident that he was given all his cigarettes, the resident got really upset and called this nurse a liar. The nurse wrote, Resident's behavior is escalating every day. Needs psych meds evaluated. A behavior progress note dated 7/30/2020 at 8:12 a.m. documented a therapist, observed the resident attempting to take cigarettes from others and became aggressive when he was denied one. A behavior progress note dated 7/30/2020 at 1:20 p.m. documented the resident was observed wandering the hallway asking frequently for a cigarette but not forced. On 8/1/2020 a behavior progress note documented the resident had been out on the smoking patio and when he returned the nurse discussed with him about giving his cigarettes and lighter to the nurse to keep in the med cart. The resident claimed that he never heard of the rule that he couldn't keep cigarettes and lighter in the room since he has been here. He was reminded that he always came to the nurses to ask for a cig when he wanted to smoke. The resident responded, Well, that's too bad. You're not getting my lighter. The resident was made aware that failure to comply with rules might have consequences. On 8/10/2020 a behavior progress note documented the resident came out of the room with a walker and approached this nurse for cigarettes. Nurse stated that he did not have any and that the resident would have to ask the finance office if he had money to purchase them. Upon offer by the nurse, the resident refused his medication. He stated, I don't want any pills. The nurse noted, but drank the water offered. The resident then stood up and stated, I don't need this (his walker) anymore, do I? and proceeded to walk without it. The nurse encouraged the resident to use the walker. The nurse wrote, the resident appeared irritated with the nurse and responded No, I don't need it and walked off with imbalance to find the finance office. Resident is currently asking anyone who is close if they have cigarettes or where the finance office is and appears irritated. A behavior progress note dated 8/11/2020 at 9:40 a.m. revealed the resident's behavior symptoms worsened. The nurse documented he exhibited agitation, confusion, grandiosity, delusions, and manic behavior. His mood was elated and he was noncompliant about not taking medications as well as use of walker. The resident told the nurse he was leaving soon and did not require any medications. Give me only cigarettes, no more pills. The note revealed the DON and assistant director of nursing (ADON) were aware of his behavior. A behavior note dated 8/11/2020 at 5:21 p.m. documented the resident became agitated, aggressive and walked out the front door. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) helped him back to the unit. The resident stated, I want to go outside. The note continued, Very stressful situations and difficult to handle due to frequent change of mood and ideas. He refused his few night medications. Providing cigarettes slightly calms him down. The resident told the nurse his medications were making him crazy so he was not taking them anymore. b. Nursing progress note A nursing progress note dated 8/13/2020 at 10:37 a.m. documented, Since beginning the shift, the resident has become confused, agitated and noncompliant. The resident told the nurse he was leaving to go to the airport. He said he was waiting for somebody. He sat on his walker and refused to go back on the unit. A male staff member accompanied the resident at the front door. The nurse documented, ADM (administrator)/DON/ADON (assistant director of nursing) were aware about this stressful and threatening situation. The resident's nurse practitioner was informed and prescribed a psychrotrophic to control behaviours. The physician met with the resident and wrote M1 hold and ordered [MEDICATION NAME] (anti anxiety medication) for agitation. The resident refused the medications. The admission coordinator and therapist tried to divert behaviours by providing coffee. Staff continued to observe his behavior. The nurse wrote, Anytime he can harm self and others due to worse dementia symptoms so everybody is cautious about his condition. He refused meds/food even cigarettes. 3. Discharge plan The discharge planning review date 8/14/2020 documented staff was working on finding resident a facility with an secured male unit for resident's safety. SS (social services) has sent multiple referrals. 4. Physician assessment A physician visit dated 8/13/2020 documented the resident was seen for altered mental status leading to behaviors of elopement and physical aggression toward nursing staff which has been escalating daily. The resident required a higher level of care to medically manage his behaviors. He had a previous admission (2017) to a psychiatric facility for suicide attempt and major [MEDICAL CONDITION] with psychotic behavior. The physician diagnosed the resident with major [MEDICAL CONDITION] with psychotic symptoms, [MEDICAL CONDITION] disorder, and paranoid disorders. His status was noted to be declined. The plan was to send the resident to the local acute care hospital for a referral to a psychiatric facility as soon as the resident was cleared. The goal was for the resident to show no signs of risk to harm self. 5. Care summary The resident's care summary, undated, was provided by the NHA via email on 9/17/2020 at 2:37 p.m. The summary was written by the NHA. The NHA documented the interventions implemented for the resident's behavior. The summary read in pertinent part, When (Resident name) admitted to the facility on [DATE] he was in need of custodial care to ensure his physical well being following a psychiatric stabilization at (psychiatric facility name) from a suicide attempt. Though he has a primary [DIAGNOSES REDACTED]. The facility has completed a clinical analysis of his condition, including lab work (Ammonia Level, CBC with differential, CMP, B12, Vitamin D, [MEDICAL CONDITION], and TSH) which showed entirely normal levels and assessments from his primary treating Nurse Practitioner, on 8/13/2020 and Physician on 8/13/2020. The facility has been unable to determine an apparent clinical cause for his change of condition. The NP started [MEDICATION NAME] 0.5mg (8/7/2020) then 1mg (8/10/2020), to no effect, and then (Resident name) began refusing medication when he ordered [MEDICATION NAME] 2.5mg to 5mg. The NP reported that the resident has Major [MEDICAL CONDITION], recurrent episode, severe, with Psychotic behavior. He also stated he has Paranoid Disorder. He ordered for the resident to discharge to the hospital in order to be admitted to a psychiatric facility for stabilization. The resident's physician concurred with this plan for further treatment. 6. Notification of transfer a. The resident's electronic record showed he had a medical durable power of attorney (MDPOA), who was also his responsible party, was appointed by the resident on 4/3/14 and a conservator appointed by the court on 3/13/18. b. The Resident Rights dated 8/15/2020 was provided to the resident upon his transfer to an acute care hospital. The rights read in pertinent part, Transfers-If you are certified, you have the right to twenty-four (24) hour notice before being transferred to another facility unless an emergency exists. You also have the right to protest to the court any such transfer, the right to notify whom you wish about the transfer, and the right to have the facility notify up to two (2) persons designated by you about your transfer. c. The resident's electronic record failed to show evidence the resident's responsible party was initially notified of the resident's behavior leading up to and including the transfer to the local acute hospital on an M1 hold, 8/15/2020. Documentation of evidence was requested from the facility; the staff provided a social services progress note dated 8/18/2020, three days after the resident was transferred to the hospital. The note read in pertinent part, NHA called (responsible person) to follow up. NHA provided an update to process improvements around family/responsible party notifications as a result of the information she had provided about contacts she should have received over the past couple of incidents. The (responsible person) was pleased with the outcome of the findings and NHA reviewed the series of events since the 7/27/2020 fall report to ensure the (responsible person) had all the information she required. A discharge progress note dated 8/14/2020 read, NHA prepared a summary of the resident's progression leading to a potential M1 hold to be sent with the resident if he did indeed require such a hold over the weekend. NHA also prepared an emergency involuntary discharge notice to potentially be given in this event. The notice was not provided to the resident nor his responsible party at this time. III. Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated Resident #1 was having increased behaviors. He was running into traffic out of the facility and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. She said he was devolving behaviorally." She wrote a summary of what was tried. She said he ran into traffic and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. She stated she did a summary and verbally spoke to (Resident #1's responsible party) about the process. The NHA was interviewed a second time on 9/17/2020 at 3:06 p.m. She stated We did not issue an involuntary discharge notice. I prepared one but didn't give it to her (responsible person). He is discharged . The director of nursing (DON) was interviewed on 9/16/2020 at 2:55 p.m. She stated, From what I know the NP (nurse practitioner) was notified every time. The nurses called, but the MDPOA (responsible party) was not listed as primary contact in the electronic system. The (conservator) was called but did not answer her phone. The DON said the system was now updated.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure two (#1 and #3) out of three reviewed for transfer/discharge out of seven sample residents, and the residents ' representative(s) were notified of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Specifically, the facility failed to provide Resident #1 and his responsible party and Resident #3, an appropriate notice of discharge that included: -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident is transferred or discharged ; -A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; -Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; -The name, address (mailing and email) and telephone number of the Office of the State; and, -For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder. I. Facility policy and procedures The Involuntary Discharge policy, dated February 2017, was provided by the NHA via email on 9/17/2020 at 2:45 p.m. The policy read in pertinent part, The Administrator or Business Office is responsible for preparing the discharge notice with input from the clinical staff as necessary. The policy documented, The template and/or state form must be in a language the resident and/or the resident's legal representative can understand and must include the following information: -The specific reason for the discharge; -The location to which the resident will be discharged ; -The anticipated discharge date ; -Specific information regarding the resident's right to appeal the discharge, instructions describing how to obtain an appeal form, and the contact information of the agency(ies) where such appeals must be filed including the name, address (mailing and email), and telephone number of each; -Information indicating that the facility will assist the resident in completing appeals forms; -The name, address and telephone number of the State Long-Term Care Ombudsman; -If the resident has developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; -If the resident has a mental disorder or related disability, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals; and -Contact information at the facility if there are questions or concerns about the involuntary discharge. The policy revealed the notice was mailed certified, return receipt, to the resident and/or the resident's legal representative, the State Long-Term Care Ombudsman and other appropriate agencies according to state guidelines. A copy of the notice is maintained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) in the resident's financial file. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident did not participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. B. Record review 1. Care plan The discharge care plan initiated 3/20/2018 and revised 1/23/2019 documented the resident wished to reside at the facility long term and discharge planning was in process for a male, secured, long term care bed due to sexually inappropriate behaviors. The goal, revised on 6/28/2020 with a target date of 9/21/2020 read, the resident's preference to stay at the facility long term will be honored. Interventions initiated 3/20/2018 and revised 1/23/2019 included to continue to monitor for sexually inappropriate behaviors. Intervene as necessary to keep other residents safe; Establish a care plan with resident/family/caregivers and evaluate progress and revise plan quarterly and PRN (as needed); Keep resident and POA (power of attorney) informed on discharge planning; and referrals have been sent to male secured units. 2. Discharge plan The discharge planning review date 8/14/2020 documented staff was working on finding resident a facility with an secured male unit for resident's safety. SS (social services) has sent multiple referrals. 3. Progress notes Reviewed behavior progress notes from 7/7/2020 through 8/15/2020 indicated an increase in dementia related symptoms of delusions, aggression, memory and mood problems. The resident exhibited behaviors of increased smoking, delusions, verbal and physical aggression, and elopement from the facility. The resident was transferred to the local hospital on [DATE] on an M1 hold (a psychological hold at hospital). A behavior progress note dated 7/7/2020 at 10:57 a.m. documented social services (SS) offered the resident a smoking holder to hold his cigarettes. SS had also explained what it was and why it was offered to him. The nurse wrote, Resident wasn't quite happy about using it and said I don't need a cigarette holder, I used to hold the cigarettes when I smoked, he was disappointed to use it. The smoker holder was kept safe on the nurses cart and offered to him every episode. On 7/7/2020 at 1:02 p.m. a behavior progress note documented the resident was aggressive when not getting a cigarette frequently. According to smoking regulations, he was able to have a cigarette every 2-3 (two to three) hours, The nurse wrote the resident asked frequently for cigarettes and if it was not received, he became agitated and shouted at the nurse. The nurse documented the resident walking away from the nurses station unhappy and after five minutes he returned to the nurses station and received a cigarette. On 7/7/2020 at 8:54 p.m. a behavior progress note documented the Resident kept asking for a cigarette every 20 minutes. When the nurse told the resident it was too early and that he was given a cigarette 20 minutes ago, the resident got really upset and started to yell saying that the nurse is not being fair. Resident forgets when he smokes and keeps coming back asking for more cigarettes every 20 minutes. A behavior progress note dated 7/18/2020 revealed the resident became agitated and aggressive when he has not received his cigarettes. He asked frequently (for cigarettes) even if he received one 10 minutes before. The note documented his cigarettes ran out on 7/18/2020. He became mad and was verbally as well as physically aggressive and wanted to leave the building. The nurse wrote, Every time is hard for him to handle the situations. We can keep our distance from him. He is also mean to other helping staff. A behavior progress note dated 7/19/2020 documented the resident became agitated and combative when asking for a cigarette. The nurse wrote, We cooperate with him by providing cigarettes every hour. Other residents also complained about his latest behavior. His behavior has changed day by day. He wanted to discharge somewhere. A behavior progress note dated 7/21/2020 read, approximately 8:00 p.m., the resident walked out of his room without the walker. When the nurse advised the resident to use a walker for safety, the resident yelled at the nurse stating I can walk without the (expletive) walker. The resident walked past the dining hall and sat in the front room. When the nurse opened the front door to let the X-ray vendor out, the resident pushed and hit the nurse. When staff tried to stop him he forced himself out the door. After a couple minutes, the nurse and CNA (certified nurse aide) were able to convince him to come in. Resident is very agitated regarding cigarettes. Since the resident is getting too aggressive, this nurse gave half a packet of cigarettes to the resident. A behavior progress note dated 7/29/2020 documented the resident was not compliant with cigarette storage. At 3:00 p.m., the resident dropped the empty cigarette storage case at the nurses desk. When this nurse ask resident what was wrong, resident stated this is stupid and I took all the cigarettes out. Since then, the resident has been asking for a cigarette every 15 minutes. When the nurse explained to the resident that he was given all his cigarettes, the resident got really upset and called this nurse a liar. The nurse wrote, Resident's behavior is escalating every day. Needs psych meds evaluated. A behavior progress note dated 7/30/2020 at 8:12 a.m. documented a therapist, observed the resident attempting to take cigarettes from others and became aggressive when he was denied one. A behavior progress note dated 7/30/2020 at 1:20 p.m. documented the resident was observed wandering the hallway asking frequently for a cigarette but not forced. On 8/1/2020, a behavior progress note documented the resident had been out on the smoking patio and when he returned the nurse discussed with him about giving his cigarettes and lighter to the nurse to keep in the med cart. The resident claimed that he never heard of the rule that he couldn't keep cigarettes and lighter in the room since he has been here. He was reminded that he always came to the nurses to ask for a cig when he wanted to smoke. The resident responded, Well, that's too bad. You're not getting my lighter. The resident was made aware that failure to comply with rules might have consequences. On 8/10/2020, a behavior progress note documented the resident came out of the room with a walker and approached this nurse for cigarettes. Nurse stated that he did not have any and that the resident would have to ask the finance office if he had money to purchase them. Upon offer by the nurse, the resident refused his medication. He stated, I don't want any pills. The nurse noted, but drank the water offered. The resident then stood up and stated, I don't need this (his walker) anymore, do I? and proceeded to walk without it. The nurse encouraged the resident to use the walker. The nurse wrote, the resident appeared irritated with the nurse and responded No, I don't need it and walked off with imbalance to find the finance office. Resident is currently asking anyone who is close if they have cigarettes or where the finance office is and appears irritated. A behavior progress note dated 8/11/2020 at 9:40 a.m. revealed the resident's behavior symptoms worsened. The nurse documented he exhibited agitation, confusion, grandiosity, delusions, and manic behavior. His mood was elated and he was noncompliant about not taking medications as well as use of walker. The resident told the nurse he was leaving soon and did not require any medications. Give me only cigarettes, no more pills. The note revealed the DON and assistant director of nursing (ADON) were aware of his behavior. A behavior note dated 8/11/2020 at 5:21 p.m. documented the resident became agitated, aggressive and walked out the front door. Staff helped him back to the unit. The resident stated, I want to go outside. The note continued, Very stressful situations and difficult to handle due to frequent change of mood and ideas. He refused his few night medications. Providing cigarettes slightly calms him down. The resident told the nurse his medications were making him crazy so he was not taking them anymore. A nursing progress note dated 8/13/2020 at 10:37 a.m. documented, Since beginning the shift, the resident has become confused, agitated and noncompliant. The resident told the nurse he was leaving to go to the airport. He said he was waiting for somebody. He sat on his walker and refused to go back on the unit. A male staff member accompanied the resident at the front door. The nurse documented, ADM (administrator)/DON/ADON (assistant director of nursing) were aware about this stressful and threatening situation. The resident's nurse practitioner was informed and prescribed a psychrotrophic to control behaviours. The physician met with the resident and wrote M1 hold and ordered [MEDICATION NAME] (anti anxiety medication) for agitation. The resident refused the medications. The admission coordinator and therapist tried to divert behaviours by providing coffee. Staff continued to observe his behavior. The nurse wrote, Anytime he can harm self and others due to worse dementia symptoms so everybody is cautious about his condition. He refused meds/food even cigarettes. 5. Assessments Social Services QuarterlyAssessment The social services quarterly assessment dated [DATE], the day before the resident was transferred to an acute care hospital for psychiatric stabilization read, Lately, the resident has been super angry with staff members because he thinks he is leaving so he is getting agitated very easy. Resident is trying to exit seek. Resident is having delusions and hallucinations of having his friends pick him up and going to the airport. He is saying that he is leaving to go to his friends house. Physician assessment A physician visit dated 8/13/2020 documented the resident was seen for altered mental status leading to behaviors of elopement and physical aggression toward nursing staff which has been escalating daily. The resident required a higher level of care to medically manage his behaviors. He had a previous admission (2017) to a psychiatric facility for suicide attempt and major [MEDICAL CONDITION] with psychotic behavior. The physician diagnosed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) the resident with major [MEDICAL CONDITION] with psychotic symptoms, [MEDICAL CONDITION] disorder, and paranoid disorders. His status was noted to be declined. The plan was to send the resident to the local acute care hospital for a referral to a psychiatric facility as soon as the resident was cleared. The goal was for the resident to show no signs of risk to harm self. 6. Notice of transfer The resident's electronic record failed to show a notice of transfer was provided to the resident or his responsible party upon his transfer to the local acute hospital on an M1 hold on 8/15/2020. The resident's notice was requested from the facility however the staff provided the following information: -The Resident Rights dated 8/15/2020 was provided to the resident upon his transfer to an acute care hospital. The rights read in pertinent part, Transfers-If you are certified, you have the right to twenty-four (24) hour notice before being transferred to another facility unless an emergency exists. You also have the right to protest to the court any such transfer, the right to notify whom you wish about the transfer, and the right to have the facility notify up to two (2) persons designated by you about your transfer. III. Resident #3 A. Resident status Resident #3, age 70, was admitted on [DATE] and discharged on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/3/2020 MDS assessment revealed the resident was not cognitively impaired with a brief BIMS of 15 out of 15. He required limited assistance with one person physical assistance for bed mobility, transfers and personal hygiene; supervision and one person physical assistance for dressing, toileting, and personal hygiene; and was independent and required set up only for eating. He had no behaviors, and rejected care one to three days a week B. Record review 1. CPO Resident #3's August 2020 CPO showed an order dated 8/21/2020 to D/C (discharge) home with medications. an order for [REDACTED]. 2. Care plan The discharge care plan initiated on 8/4/2020 and discontinued on 8/25/2020 documented the resident wished to return to the community upon discharge. The intervention was to make arrangements with required community resources to support independence post-discharge as needed. 3. Progress notes A nursing progress note dated 8/22/2020 showed the resident was discharged home with medications and his personal belongings. He was picked up by transportation and his discharge papers were signed. The resident's electronic record failed to show a notice of discharge was provided to the resident upon his discharge back home. IV. Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated Resident #1 was having increased behaviors. He was running into traffic out of the facility and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. She said he was devolving behaviorally." She wrote a summary of what was tried. She said he ran into traffic and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. She stated she did a summary and verbally spoke to her (Resident #1's responsible person) about the process. She stated We don ' t do a formal discharge notice, we do discharge planning. The SSD stated anyone with dementia [DIAGNOSES REDACTED]. The physician was contacted to determine the need for M1 hold. We determine if there are interventions to put in place prior and what was tried. She said the resident had severe mental health issues. She stated, Resident #3 was a planned discharge and had a discharge summary. We don't do a discharge notice for planned discharge. We would give notice if benefits ran out. She said Resident #1 had severe mental health issues and was sent out on M1 hold. We had the M1 signed. The NHA was interviewed a second time on 9/17/2020 at 3:06 p.m. She stated We did not issue an involuntary discharge notice. I prepared one but didn't give it to her (responsible person). He is now discharged .
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to ensure one (#1) out of three out of seven sample residents and resident representatives were provided with written notice of the facility's Bed-hold notice upon transfer. Specifically the facility failed to provide Resident #1 and his responsible party a bed-hold notice prior to transfer/discharge to the hospital. I. Policy and procedures The Bed Hold / Leave of Absence policy, dated July 2016, was provided by the nursing home administrator (NHA) via email on 9/17/2020 at 2:37 p.m. The policy read in pertinent part, The facility provides written notification of the bed hold/leave of absence policy to all residents and/or responsible parties upon admission, and at the time of leave of absence or transfer, in accordance with Federal and State regulations. The Communication section of the policy read, All interdisciplinary team members must be aware of these policies as well as requirements for communicating these policies to residents and/or responsible parties. The policy documented when the facility provided the notification of the policy. It included: -Upon admission or Leave of Absence, a facility designee will provide the resident and/or responsible party written information concerning the option to exercise the Bed Hold/Leave of Absence policy. -Upon Leave of Absence, a Bed Hold Authorization form is distributed to the resident and/or responsible party. -The Bed Hold Authorization form will include the Bed Hold Rate and the Bed Hold Days (if applicable). -A copy of the Bed Hold Authorization form must be sent with the resident at the time of transfer. In case of emergency transfer, written notice to the resident and/or responsible party is provided within 24 hours of the transfer. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident did not participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. B. Record review 1. Discharge progress notes A discharge note dated 8/14/2020 documented the NHA prepared a summary of the resident's progression leading to a potential M1 hold to be sent with the resident if he did indeed require such a hold over the weekend. NHA also prepared an emergency involuntary discharge notice to potentially be given in this event. The notice was not provided to the resident nor his responsible party at this time. The discharge progress note dated 8/15/2020 revealed the hospital nurse case manager inquired as to a summary of the care needs for Resident #1 that culminated in the M1 hold. NHA explained that a summary of his decline in mentation and the facility's inability to find a clinical source for the change was included in his packet, along with a letter for Resident #1 explaining in writing the facility's desire to have him placed elsewhere after his stay in the hospital. The NHA explained that this was an emergent discharge and that if he could not be otherwise stabilized, he would be unable to return to the facility due to his violence toward staff members, potential for harming others, and his endangerment of himself with repeated elopement attempts and disregard for traffic outside the facility. The case manager said they would be seeking a gero-psych evaluation along with clinical workup. 2. Care summary The resident's care summary, undated, was provided by the NHA via email on 9/17/2020 at 2:37 p.m. The NHA documented the interventions implemented for the resident's behavior. The summary read in pertinent part, Though he has a primary [DIAGNOSES REDACTED]. The facility has completed a clinical analysis of his condition, including lab work (Ammonia Level, CBC with differential, CMP, B12, Vitamin D, [MEDICAL CONDITION], and TSH) which showed entirely normal levels and assessments from his primary treating Nurse Practitioner, on 8/13/2020 and Physician on 8/13/2020. The facility has been unable to determine an apparent clinical cause for his change of condition. The NP started [MEDICATION NAME] 0.5mg (8/7/2020) then 1mg (8/10/2020), to no effect, and then (Resident name) began refusing medication when he ordered [MEDICATION NAME] 2.5mg to 5mg. The NP reported that the resident has Major [MEDICAL CONDITION], recurrent episode, severe, with Psychotic behavior. He also stated he has Paranoid Disorder. He ordered for the resident to discharge to the hospital in order to be admitted to a psychiatric facility for stabilization. The resident's physician concurred with this plan for further treatment.The nature of the care Resident #1 needs is not provided at his present placement facility. The facility lacks the ability to involuntarily or covertly administer medications under its licensure parameters and cannot continue to ensure his safety. (Facility name) does not provide the type of psychological stabilization and treatment of [REDACTED]. The facility has determined the resident is inappropriate for placement in this facility and has issued an immediate Involuntary Discharge notice along with the issuance of an Ml hold. The facility has sought placement in a psychiatric stabilization unit after his transfer to the Emergency Department. 3. Resident rights The Resident Rights dated 8/15/2020 was provided to the resident upon his transfer to an acute care hospital. The rights read in pertinent part, Transfers-If you are certified, you have the right to twenty-four (24) hour notice before being transferred to another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) facility unless an emergency exists. You also have the right to protest to the court any such transfer, the right to notify whom you wish about the transfer, and the right to have the facility notify up to two (2) persons designated by you about your transfer. -The resident rights did not meet the requirements for a bed-hold policy nor was the resident's responsible person notified. III. Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated the resident was having increased behaviors. He was running into traffic out of the facility and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. The SSD stated anyone with dementia [DIAGNOSES REDACTED]. The physician was contacted to determine the need for M1 hold. We determine if there are interventions to put in place prior and what was tried. She said the resident had severe mental health issues. The NHA said something acute was happening with him. He had paranoia, was chain smoking, and was unsafe to be in the building. She said they wanted to get to the bottom of this. When he was sent back from the hospital he objected. When he came back on 8/21/2020, he was quarantined and required a one-to-one staff supervision. He broke out a window and was stepping on the glass. He was sent out on another M1 hold. The NHA was interviewed a second time on 9/17/2020 at 3:55 p.m. The NHA stated The Bed Hold policy essentially holds a room regardless if no one goes back to the same room or because of quarantine. She said the facility had a large capacity of beds and always had beds open. She said the resident and responsible parties were provided with the Bed-Hold policy as part of their admission agreement. She said the policy was also part of the discharge process and the nurse reviewed it with the resident at the time of discharge. She said The only reason we wouldn ' t hold a bed was if the facility was at 90% capacity. She said it was part of the regular discharge summary. She stated the resident Did not get a Bed Hold policy (when he was transferred to the hospital on an M1 hold), instead he was given a copy of his rights, and he refused to sign. His responsible party was called after the fact. She said We anticipated him to return.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the comprehensive care plans for two (#1, #2) residents out of three sample residents were reviewed and revised by the interdisciplinary team. Specifically, the facility failed to: -Update comprehensive care plan with appropriate interventions for Resident #1 with escalating behaviors (physical and verbal aggression, increased smoking and elopement) and effective interventions; and, -Update comprehensive care plan with appropriate interventions for Resident #2 after she was re-evaluated for self-administration of medications. Cross-reference to F554, for Resident #2 (evaluation for self-administration of medications). Findings include: I. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident refused to participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. B. Record review 1. Dementia care plan The dementia care plan initiated 3/26/18 and revised on 8/20/2020 revealed the resident had a behavior problem related to dementia. The care plan documented he had a history of [REDACTED]. According to the care plan he was easily redirected. Interventions initiated on 4/4/18 included: Administer medications as ordered. Observe/document for side effects and effectiveness; allow choices within resident's decision making abilities; anticipate and meet resident's needs; caregivers to provide opportunity for positive interaction, attention. Stop and talk with him as passing by; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention and remove from situation and take to alternate location as needed; minimize potential for resident's disruptive behaviors by offering tasks which divert attention; notify MD (medical doctor) as needed; observe behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes; and if reasonable, discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. As of 1/16/2019, the resident was on the waitlist for a male only secured unit. -The dementia care plan documented it was revised on 8/20/2020, however, it was not updated with the new behaviors related to his dementia of delusions, aggression, memory and mood problems or effective interventions for increased behaviors related to his dementia. The behaviors documented in the dementia care plan were not exhibited by the resident at the time. The care plan also failed to include interventions when the resident was escalating and not responding to staff interactions. 2. Progress notes a. Nursing progress notes A nursing progress note dated 7/26/2020 documented in pertinent part, the resident wanted to talk to this nurse as he was worried that his brother was going to find a way into the building and shoot him. The resident was reassured that our facility is a locked facility and safety codes are in place. Resident asked the nurse what she would do if his brother came in with a gun. The resident was reassured that 911 would be called and CPI-Controlled Preventative Interventions utilized as a team for everyone's safety. Resident stated, You don't know my brother, can you give me a ride to my best friends? He doesn't know where he lives. The nurse began to assess his pain, urination, and bowel functions. The Resident stated, Ok, normal, but no one is listening to me. My brother is going to get in here and kill me. Don't let that happen ok? The resident was validated and reassured that all of us are listening to him and we are going to keep him safe tonight and every night to the best of our ability. Resident stated Ok. and went to his room. A nursing progress note dated 8/6/2020 documented the resident refused to take a shower in the morning. The resident stated I will take shower when I go home, which will be today. A nursing progress note dated 8/11/2020 at 3:59 a.m. documented at 10:15 p.m. , the resident walked out the front door. When redirected, the resident stated, he is waiting for his friend to pick him up and to go to the airport. I want to go far away from this place. He was noted to walk to the parking lot and waited from 2215 (10:15 p.m.) until 0130 (1:30 a.m.). A staff person stayed with the resident as he refused to return to the facility. The director of nursing (DON) and local police were called. The resident continued to refuse to return to the facility. At 1:35 a.m. the resident went inside to use the bathroom. He was given snacks and encouraged to lie in bed but refused to stay in his room. He finished his snack at the nurses station then decided to go outside again at 2:00 a.m When re-directed the resident got really upset and started yelling/hitting and swinging his walker around. The resident stated I want to kill you. The local police were called again. The resident started to calm down after police arrived. The note documented the staff continued to babysit resident rest of the night. A nursing progress note dated 8/13/2020 at 10:37 a.m. documented, Since beginning the shift, the resident has become confused, agitated and noncompliant. The resident told the nurse he was leaving to go to the airport. He said he was waiting for somebody. He sat on his walker and refused to go back on the unit. A male staff member accompanied the resident at the front door. The nurse documented, ADM (administrator)/DON/ADON (assistant director of nursing) were aware about this stressful and threatening situation. The resident's nurse practitioner was informed and prescribed a psychrotrophic to control behaviours. The physician met with the resident and wrote M1 hold (a psychological hold at hospital) and ordered [MEDICATION NAME] (anti anxiety medication) for agitation. The resident refused the medications. The admission coordinator and therapist tried to divert behaviours by providing coffee. Staff continued to observe his behavior. The nurse wrote, Anytime he can harm self and others due to worse dementia symptoms so everybody is cautious about his condition. He refused meds/food even cigarettes. -The progress notes showed episodes of behaviors of delusions, aggression, memory and mood problems related to his dementia. There was no documentation in the record of behaviors that included going behind the nurse's station looking for snacks and drinks and a history of being sexually inappropriate with female residents. 3. Increased smoking care plan The resident's smoking care plan initiated 10/17/19 and revised 10/24/19 documented the resident was a safe smoker and was physically able to light, smoke, and extinguish his own cigarette. He had been educated on the facility smoking policy and the designated smoking areas. The goal, initiated on 10/17/19, was to not suffer injury from unsafe smoking practices through the review date. Although the goal was documented as revised on 6/28/2020 with a new target date of 9/21/2020, the goal itself was not revised. Interventions included: assess quarterly, PRN (as needed), and with each smoking violation for continued safety with smoking; instruct the resident about smoking risks and hazards and about smoking cessation aids that are available; instruct the resident about the facility smoking policy locations, times and safety concerns; notify charge nurse immediately if it is suspected that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) resident has violated the smoking policy; and observe clothing and skin for signs of burns. The facility stored the resident's cigarettes. The care plan failed to address the resident's new behaviors of increased smoking, aggression and elopement related to the resident's smoking. Nor did it document new or effective interventions for staff to use. The behaviors related to smoking were not about proper use of and cigarette safety. a. Social services progress note A social services (SS) progress note dated 7/6/2020 documented SS offered the resident a smoking holder to hold his cigarettes. SS explained to the resident what it was and why it was offered to him. The note revealed the resident wasn't happy about it and said I don't need a cigarette holder, I've been smoking for many years so I'm not going to use it. It was given to the nurse so she can lock it up in the nurses station so it's available and the nurses can offer it every time he goes outside to smoke. b. Behavior progress notes A behavior progress note dated 7/7/2020 at 10:57 a.m. documented social services (SS) offered the resident a smoking holder to hold his cigarettes. SS had also explained what it was and why it was offered to him. The nurse wrote, Resident wasn't quite happy about using it and said I don't need a cigarette holder, I used to hold the cigarettes when I smoked, he was disappointed to use it. The smoker holder was kept safe on the nurses cart and offered to him every episode. On 7/7/2020 at 1:02 p.m. a behavior progress note documented the resident was aggressive when not getting a cigarette frequently. According to smoking regulations, he was able to have a cigarette every 2-3 (two to three) hours, The nurse wrote the resident asked frequently for cigarettes and if it was not received, he became agitated and shouted at the nurse. The nurse documented the resident walking away from the nurses station unhappy and after five minutes he returned to the nurses station and received a cigarette. On 7/7/2020 at 8:54 p.m. a behavior progress note documented the Resident kept asking for a cigarette every 20 minutes. When the nurse told the resident it was too early and that he was given a cigarette 20 minutes ago, the resident got really upset and started to yell saying that the nurse is not being fair. Resident forgets when he smokes and keeps coming back asking for more cigarettes every 20 minutes. A behavior progress note dated 7/18/2020 revealed the resident became agitated and aggressive when he has not received his cigarettes. He asked frequently (for cigarettes) even if he received one 10 minutes before. The note documented his cigarettes ran out on 7/18/2020. He became mad and was verbally as well as physically aggressive and wanted to leave the building. The nurse wrote, Every time is hard for him to handle the situations. We can keep distance from him. He is also mean to other helping staff. A behavior progress note dated 7/19/2020 documented the resident became agitated and combative when asking for a cigarette. The nurse wrote, We cooperate with him by providing cigarettes every hour. Other residents also complained about his latest behavior. His behavior has changed day by day. He wanted to discharge somewhere. A behavior progress note dated 7/21/2020 read, approximately 8:00 p.m., the resident walked out of his room without the walker. When the nurse advised the resident to use a walker for safety, the resident yelled at the nurse stating I can walk without the (expletive) walker. The resident walked past the dining hall and sat in the front room. When the nurse opened the front door to let the X-ray vendor out, the resident pushed and hit the nurse. When staff tried to stop him he forced himself out the door. After a couple minutes, the nurse and CNA (certified nurse aide) were able to convince him to come in. Resident is very agitated regarding cigarettes. Since the resident is getting too aggressive, this nurse gave half a packet of cigarettes to the resident. A behavior progress note dated 7/29/2020 documented the resident was not compliant with cigarette storage. At 3:00 p.m., the resident dropped the empty cigarette storage case at the nurses desk. When this nurse ask resident what was wrong, resident stated this is stupid and I took all the cigarettes out. Since then, the resident has been asking for a cigarette every 15 minutes. When the nurse explained to the resident that he was given all his cigarettes, the resident got really upset and called this nurse a liar. The nurse wrote, Resident's behavior is escalating every day. Needs psych meds evaluated. A behavior progress note dated 7/30/2020 at 8:12 a.m. documented a therapist, observed the resident attempting to take cigarettes from others and became aggressive when he was denied one. A behavior progress note dated 7/30/2020 at 1:20 p.m. documented the resident was observed wandering the hallway asking frequently for a cigarette but not forced. On 8/1/2020 a behavior progress note documented the resident had been out on the smoking patio and when he returned the nurse discussed with him about giving his cigarettes and lighter to the nurse to keep in the med cart. The resident claimed that he never heard of the rule that he couldn't keep cigarettes and lighter in the room since he has been here. He was reminded that he always came to the nurses to ask for a cig when he wanted to smoke. The resident responded, Well, that's too bad. You're not getting my lighter. The resident was made aware that failure to comply with rules might have consequences. On 8/10/2020 a behavior progress note documented the resident came out of the room with a walker and approached this nurse for cigarettes. Nurse stated that he did not have any and that the resident would have to ask the finance office if he had money to purchase them. Upon offer by the nurse, the resident refused his medication. He stated, I don't want any pills. The nurse noted, but drank the water offered. The resident then stood up and stated, I don't need this (his walker) anymore, do I? and proceeded to walk without it. The nurse encouraged the resident to use the walker. The nurse wrote, the resident appeared irritated with the nurse and responded No, I don't need it and walked off with imbalance to find the finance office. Resident is currently asking anyone who is close if they have cigarettes or where the finance office is and appears irritated. c. Nursing progress notes A nursing progress note dated 8/6/2020 documented, Resident continues to request a cigarette every 15-20 minutes. A nursing progress note dated 8/12/2020 documented, Resident much calmer tonight. This nurse smelled cigarette smoke in the resident room while doing rounds at 2300 (11:00 p.m). Roommate said the resident was smoking in the room. Resident was sleeping soundly at the time. Removed lighter from resident's bed side table. -The progress notes indicated the resident was smoking more cigarettes than he normally did. The increase in smoking/chain smoking resulted in the resident running out of cigarettes and the money to buy more. Staff attempted to reason with him and have him ration his cigarettes to avoid running out. The resident was given a box with a timer to help him remember to wait for the scheduled cigarette break. Staff purchased cigarettes for the resident, with their own money, to prevent the resident's aggressive behavior. Although staff attempted interventions, they were not effective. The root cause of the increased smoking was not determined and interventions attempted by staff were not effective. There was no evidence in the record to show the resident was an unsafe smoker. 4. Wandering with elopement a. Care plan The elopement care plan initiated on 4/24/2018 and revised 7/22/2020 showed the resident was an elopement risk related to ETOH dementia. With consent from legal guardian, the resident's wander guard is placed on his FWW (four wheeled walker) due to history of removing the wander guard from his body. The goal initiated 7/22/2020 with a target date of 9/21/2020 documented the resident's safety will be maintained through the review date. The resident will demonstrate happiness with daily routine through the review date. The resident will not leave the facility unattended through the review date. The interventions initiated on 4/24/20 and documented as revised on 7/23/2020 included the following: Assess for fall risk; Check placement and function of safety monitoring device every shift; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Observe for fatigue and weight loss; Observe location at regular and frequent intervals; Document wandering behavior and attempted diversional interventions; Offer emotional and psychological support; Orient resident to environment; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; and Reorient/validate and redirect the resident as needed. -The elopement care plan showed it had been revised on 7/23/2020 however, the date of the goal was updated. No new interventions were developed to address the residents elopement behavior he exhibited at the time. b. Progress notes A nursing progress note dated 7/22/2020 documented the nurse Placed wander guard on left wrist, explained rationale to resident and he is agreeable to wearing it. A care conference note dated 7/23/2020 read in pertinent part, IDT (interdisciplinary team) met to review recent increase in possible elopement type behaviors. Behaviors are tied to cigarettes or lack thereof. We supplied cigarettes and stored them in the north med room for easy access 24/7. Wander guard placed on, he removed it immediately. Wander guard placed on the walker which he does not use all the time. On 15 minute checks. A behavior progress note dated 8/7/2020 read, Received call from exiting employee stating resident has pushed door open & is outside. Staff unable to successfully redirect resident back inside facility. Resident intends to walk to convenience store across the street to purchase cigarettes. Staff x2 (two) accompanied resident across the street, while contacting 911 for assistance with encouraging resident to return to facility. 911contacted at 1635 (4:35 p.m.) per staff member. Resident inside facility at 1657 (4:57 p.m.). Resident placed on 1:1 (one-to-one) supervision. Resident removed the wanderguard. Wanderguard was replaced upon return to the facility. A behavior progress note dated 8/7/2020 documented the resident walked out of the front door without consent. He became agitated, aggressive and waited for somebody to pick him up. The nurse documented the resident was upset about staying in the building and tried to leave. He was redirected but refused. He became aggressive back in the building and pushed the walker into a staff person. His walker fell on the ground and he lost his balance and fell on the floor. He refused a physical assessment and vital signs. His PCP (primary care physician) was notified. The PCP wrote a new order for [MEDICATION NAME] (antipsychotic) 1mg (milligram) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) CBC (complete blood count)/CMP(comprehensive metabolic panel)/Ammonia (lab) on Sunday. A behavior progress note dated 8/11/2020 documented the Resident used to participate in a scheduled smoking program without incident. He also allowed wanderguard placement. Now he does neither. We have notified PCP who ordered labs, reviewed meds, and added new med, [MEDICATION NAME]. We will continue to seek placement in secured male unit but have been unsuccessful with finding placement. He is on 15 minute checks and staff accompanies him as needed. A nursing progress note dated 8/12/2020 documented the resident was at the front door pushing it open, alarm sounding. Staff were unable to redirect him and he attempted to punch the nurse. The NP (nurse practitioner) was called and the resident's [MEDICATION NAME] was increased to 1.0 mg Q (every) HS (night). -All progress notes revealed the resident attempted or eloped from the facility for different reasons. The resident had delusions related to dementia and eloped to wait for a friend from [AGE] years past, to catch an airplane or to go live with his friend, and to go buy cigarettes. It was documented the resident was to wear a wanderguard to sound the alarm when the resident opened the doors however, he kept removing and hiding it from staff. The wanderguard was then placed on his walker and he began to leave his walker behind or use it as a weapon against staff when attempting to leave. The care plan failed to include intervention related to the reasons the resident eloped. C.Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated the resident was having increased behaviors. He was running into traffic out of the facility and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold on 8/15/2020. The SSD stated anyone with dementia [DIAGNOSES REDACTED]. The physician was contacted to determine the need for M1 hold. We determine if there are interventions to put in place prior and what was tried. She said the resident had severe mental health issues. The NHA said something acute was happening with him. He had paranoia, was chain smoking, and was unsafe to be in the building. The NHA communicated via email on 9/17/2020 at 11:57 a.m., The NHA wrote, in pertinent part, The one-on-one (staff supervision) was implemented for (Resident #1 Name) on 8/1/2020 upon his first elopement attempt. Staff members were directed to continue with 1:1 supervision when actively exit seeking, but at other times when he was not exit-seeking, the individual monitoring was not necessary. The front door alarms, regardless of placement of wander guard, due to the current COVID precautions, activate whenever the door is pulled and thus would alert staff members if he attempted to exit. 15 mins checks were done to determine when the resident starts to actively exit seek. Additionally, maintaining the resident's individual space without monitoring reduced his level of agitation as he was displaying paranoia when he saw somebody following him around the facility. The DON was interviewed on 9/16/2020 at 2:55 p.m.The DON stated, the resident's target behaviors were agitation, verbal and physical aggression and elopement. She said she had not known of him going into female resident's rooms. She said that was before me, I started June 2019. She said his behavior started to increase June 2020 but was more noticeable in July 2020. Prior to the recent behaviors, he just walked around and asked for cigarettes and then went to smoke every two hours. He started to increasingly ask for cigarettes and then forgot he already asked. He got aggravated and mad. He was verbally aggressive to staff and a couple of times physically aggressive hitting them with his walker. We figured out a way for him to have cigarettes more often. They were put in a box in which he had access to. She said it did not work; he was still agitated with the box. When his behaviors started to increase he then had it in mind he had to leave. He would go outside because he said he had a friend that was going to pick him up or he had to go to the airport. She said it was a friend of his from [AGE] years ago. She said they tried to find him but were not able to. The DON stated the resident cut off his wander guard. She said she did not know how he did it and he wouldn ' t tell them. They searched his room but could not find anything he would be able to use to cut it off. She said he would not tell us where he put it and we had to buy new ones. She said they placed it on his walker then he started leaving his walker and not using it. She said the wanderguard was checked by staff every shift. Staff documented the wander guard check on the EMAR (electronic medication administration record). She said, at first he was able to redirect, then it became harder. He figured out how to open the front door by pushing on it for 15 sec. When the alarm went off, staff followed and redirected him. When he was in the parking lot on 8/15/2020 he wasn ' t able to be redirected. She said he had to be sent out to the hospital on a M1 hold. When he returned on 8/21/2020 he was agitated and threw a bedside table at a window to get out. He refused treatment from the nurse. The medical director was called and he was put on a second M1 hold. The NHA and the DON were interviewed a second time on 9/17/2020 at 3:06 p.m. The NHA stated a one to one was started on 8/1/2020 to have someone with him to occupy him but sometimes it was not needed. A CNA (certified nurses aide) was assigned to him only when he was exit seeking. Prior to the increase in his behaviors, he wandered within the building usually from his room to the smoking area and back. He would go have a cigarette and then go back to his room. The behaviors we saw were more like an anxiety, a need to go somewhere. She said he used a walker as a weapon to hit staff and he punched staff. When anyone would get too close he would physically react. She said they used 15 minute checks as staff were accustomed to do it regularly for his sexually inappropriate behaviors. She said at first we thought the increase in behavior was attributed to just the smoking, then he started saying he had a friend to come get him. He began getting paranoid at the end of July (2020). He was paranoid with staff wearing masks. It was explained to him that the staff had to wear the masks because of COVID. He refused to wear the masks, he said COVID was over. She said the care plan was updated if there is a new intervention or pattern of behavior. The NHA confirmed the resident's care plan was not updated. The resident came up for two weeks in morning meetings due to his escalation. She said they discussed the resident's behavior daily to determine what to do differently. The DON said the team usually talked about it in morning meetings, then we would go to the nurses and tell them to try this or that (for his behaviors). We did not document what was tried. She said the SSD was supposed to update the care plan. The SSD was unavailable at the time for an interview. II. Resident #2 A. Resident status Resident #2, age 58, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 7/29/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance of two and more people with activities of daily living. B. Record review The most recent self administration assessment was dated 7/7/2020 and read: Resident would like her medications to be kept in a locked cabinet in her room and administered by the nurse. The care plan for self-administration of medications, initiated 2/12/2020 and revised 5/1/2020, identified the resident was able to self-administer all of her medications. Interventions included to evaluate resident quarterly and as needed, monitor for proper storage and usage of medications. The care plan was not updated on 7/7/2020 when the resident was re-evaluated for self- administration in the presence of the nurse. C. Resident interview Resident #2 was interviewed on 9/15/2020 around 3:20 p.m. Resident was in bed on her right side facing the door. She said she does not trust nurses with her medications and all her medications are kept in her room in a locked box at the table next to her. She said she is the only person who has access to the box and she independently took her medications for at least a month. Resident said she had in her possession [MEDICATION NAME], aspirin, [MEDICATION NAME], an [MEDICATION NAME] inhaler and vitamin D. She said she was able to administer all these medications independently. D. Staff interviews The nurse practitioner (NP) was interviewed on 9/15/2020 at 3:00 p.m. He said he recall having a conversation with Resident #2 regarding self-administration of her medications. He said Resident #2 was determined capable of administering her own medications. He reviewed his notes and said he gave an order to nursing staff some time after 7/7/2020 to allow the resident to self administer all of her medications. Licensed practical nurse (LPN) #1 was interviewed on 9/16/2020 around 11:30 a.m. She said she frequently worked with resident and was a full time nurse on the unit where Resident #2 resided. She said the resident was self-administering all of her medications. She said Resident #2 did not like her and did not want her in her room, she said every time I walked in her room she cursed and told me to get out. LPN#1 said she was not able to assess what medications the resident took because Resident #2 refused to talk to her. She said the director of nursing (DON) and other staff members were aware that the resident disliked many staff members and was not cooperative with care. She said it was not part of her responsibilities to update care plans. Registered nurse (RN) #1 was interviewed on 9/17/2020 around 2:00 p.m. She said the resident was particular about her care and oftentimes verbally abusive and inappropriate. She said the resident had an order for [REDACTED].#2 would not show. She said she would ask the resident if she took her medications, but she did not document that anywhere. She said the resident was only self administering scheduled medications. All as needed medications were administered by nurses. She said she did update care plans occasionally, but it was not her primary responsibility. The DON was interviewed on 9/17/2020 at 2:15 p.m. She said care plans related to nursing care were updated by nurse managers. She said care plan for Resident #2 should have been updated with new interventions based on the most current physician orders [REDACTED].#2's care plan was missed and not updated after the assessment on 7/7/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8)
F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being for one (#1) of three out of seven sample residents reviewed. Specifically, the facility failed to develop individualized interventions due to the progression of his aggressive behaviors, increased smoking and wandering with elopement. Findings include: I. Facility policy and procedure The Care of Resident with Dementia policy, dated October 2017, was provided by the nursing home administrator via email on 9/17/2020 at 2:37 p.m. The policy read in pertinent part, Residents who display symptoms or are diagnosed with [REDACTED]. Providing care and services for residents living with dementia or dementia-like symptoms is an integral part of the person-centered care environment. This environment supports quality of life, meaningful relationships, and positive engagement. The policy documented the treatments and services provided by the facility staff, that included but were not limited to: -Medical care, diagnosis, and support based on [DIAGNOSES REDACTED]., choices, and preferences while maximizing their dignity, autonomy, privacy, socialization, independence, choice, and safety; -Individualized, non-pharmacological approaches to care that are purposeful and meaningful to the resident to enhance their well-being; and -Specialized activities, nutrition, and/or environmental modifications are included in the care plan based on the resident's abilities and challenges. Goals are identified and interventions are implemented, taking into account the resident's symptomology and rate of progression, to include resources necessary to support the resident's success and achievement. The care plan is monitored for effectiveness routinely and updated, as needed, to reflect the needs of the resident. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident did not participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. III. Record review A. Dementia care plan The dementia care plan initiated 3/26/18 and revised on 8/20/2020 revealed the resident had a behavior problem related to dementia. The care plan documented he had a history of [REDACTED]. According to the care plan he was easily redirected. Interventions initiated on 4/4/18 included: Administer medications as ordered. Observe/document for side effects and effectiveness; allow choices within resident's decision making abilities; anticipate and meet resident's needs; caregivers to provide opportunity for positive interaction, attention. Stop and talk with him as passing by; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention and remove from situation and take to alternate location as needed; minimize potential for resident's disruptive behaviors by offering tasks which divert attention; notify MD (medical doctor) as needed; observe behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes; and if reasonable, discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. As of 1/16/2019, the resident was on the waitlist for a male only secured unit. Although the care plan documented it was revised on 8/20/2020, it was not updated with the new behaviors related to his dementia of delusions, aggression, memory and mood problems or effective interventions for increased behaviors related to his dementia. The behaviors documented in the dementia care plan were not exhibited by the resident at the time. B. Progress notes 1. Nursing progress notes A nursing progress note dated 7/26/2020 documented in pertinent part, the resident wanted to talk to this nurse as he was worried that his brother was going to find a way into the building and shoot him. The resident was reassured that our facility is a locked facility and safety codes are in place. Resident asked the nurse what she would do if his brother came in with a gun. The resident was reassured that 911 would be called and CPI-Controlled Preventative Interventions utilized as a team for everyone's safety. Resident stated, You don't know my brother, can you give me a ride to my best friends? He doesn't know where he lives. The nurse began to assess his pain, urination, and bowel functions. The Resident stated, Ok, normal, but no one is listening to me. My brother is going to get in here and kill me. Don't let that happen ok? The resident was validated and reassured that all of us are listening to him and we are going to keep him safe tonight and every night to the best of our ability. Resident stated Ok. and went to his room. A nursing progress note dated 8/6/2020 documented the resident refused to take a shower in the morning. The resident stated I will take shower when I go home, which will be today. A nursing progress note dated 8/11/2020 at 3:59 a.m. documented at 10:15 p.m. , the resident walked out the front door. When redirected, the resident stated, he is waiting for his friend to pick him up and to go to the airport. I want to go far away from this place. He was noted to walk to the parking lot and waited from 2215 (10:15 p.m.) until 0130 (1:30 a.m.). A staff person stayed with the resident as he refused to return to the facility. The director of nursing (DON) and local police were called. The resident continued to refuse to return to the facility. At 1:35 a.m. the resident went inside to use the bathroom. He was given snacks and encouraged to lie in bed but refused to stay in his room. He finished his snack at the nurses station then decided to go outside again at 2:00 a.m When re-directed the resident got really upset and started yelling/hitting and swinging his walker around. The resident stated I want to kill you. The local police were called again. The resident started to calm down after police arrived. The note documented the staff continued to babysit resident rest of the night. A nursing progress note dated 8/13/2020 at 10:37 a.m. documented, Since beginning the shift, the resident has become confused, agitated and noncompliant. The resident told the nurse he was leaving to go to the airport. He said he was waiting for somebody. He sat on his walker and refused to go back on the unit. A male staff member accompanied the resident at the front door. The nurse documented, ADM (administrator)/DON/ADON (assistant director of nursing) were aware about this stressful and threatening situation. The resident's nurse practitioner was informed and prescribed a psychrotrophic to control behaviours. The physician met with the resident and wrote M1 hold (emergency mental health hold procedure) and ordered [MEDICATION NAME] (anti anxiety medication) for agitation. The resident refused the medications. The admission coordinator and therapist tried to divert behaviours by providing coffee. Staff continued to observe his behavior. The nurse wrote, Anytime he can harm self and others due to worse dementia symptoms so everybody is cautious about his condition. He refused meds/food even cigarettes. 2. Behavior progress notes A behavior progress note dated 8/11/2020 at 9:40 a.m. revealed the resident's behavior symptoms worsened. The nurse documented he exhibited agitation, confusion, grandiosity, delusions, and manic behavior. His mood was elated and he was noncompliant about not taking medications as well as use of walker. The resident told the nurse he was leaving soon and did not require any medications. Give me only cigarettes, no more pills. The note revealed the DON and assistant director of nursing (ADON) were aware of his behavior. A behavior note dated 8/11/2020 at 5:21 p.m. documented the resident became agitated, aggressive and walked out the front door. Staff helped him back to the unit. The resident stated, I want to go outside. The note continued, Very stressful situations and difficult to handle due to frequent change of mood and ideas. He refused his few night medications. Providing cigarettes slightly calms him down. The resident told the nurse his medications were making him crazy so he was not taking them anymore. Progress notes indicated an increase in dementia related symptoms of delusions, aggression, memory and mood problems, however the dementia care plan and interventions did not address the behaviors exhibited at the time and were not effective in redirecting the resident from dementia related behavior. C. Increased smoking care plan The resident's smoking care plan initiated 10/17/19 and revised 10/24/19 documented the resident was a safe smoker and was physically able to light, smoke, and extinguish his own cigarette. He had been educated on the facility smoking policy and the designated smoking areas. The goal, initiated on 10/17/19, was to not suffer injury from unsafe smoking practices through the review date. Although the goal was documented as revised on 6/28/2020 with a new target date of 9/21/2020, the goal itself was not revised. Interventions included: assess quarterly, PRN (as needed), and with each smoking violation for continued safety with smoking; instruct the resident about smoking risks and hazards and about smoking cessation aids that are available; instruct the resident about the facility smoking policy locations, times and safety concerns; notify charge nurse immediately if it is suspected that the resident has violated the smoking policy; and observe clothing and skin for signs of burns. The facility stored the resident's cigarettes. The care plan failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) address the resident's new behaviors of increased smoking, aggression and elopement related to the resident's smoking. Nor did it document new or effective interventions for staff to use. The behaviors related to smoking were not about proper use of and cigarette safety. 1. Progress notes a. Social services/behavior progress notes A social services (SS) progress note dated 7/6/2020 documented SS offered the resident a smoking holder to hold his cigarettes. SS explained to the resident what it was and why it was offered to him. The note revealed the resident wasn't happy about it and said I don't need a cigarette holder, I've been smoking for many years so I'm not going to use it. It was given to the nurse so she can lock it up in the nurses station so it's available and the nurses can offer it every time he goes outside to smoke. b. Behavior progress notes A behavior progress note dated 7/7/2020 at 10:57 a.m. documented social services (SS) offered the resident a smoking holder to hold his cigarettes. SS had also explained what it was and why it was offered to him. The nurse wrote, Resident wasn't quite happy about using it and said I don't need a cigarette holder, I used to hold the cigarettes when I smoked, he was disappointed to use it. The smoker holder was kept safe on the nurses cart and offered to him every episode. On 7/7/2020 at 1:02 p.m. a behavior progress note documented the resident was aggressive when not getting a cigarette frequently. According to smoking regulations, he was able to have a cigarette every 2-3 (two to three) hours, The nurse wrote the resident asked frequently for cigarettes and if it was not received, he became agitated and shouted at the nurse. The nurse documented the resident walking away from the nurses station unhappy and after five minutes he returned to the nurses station and received a cigarette. On 7/7/2020 at 8:54 p.m. a behavior progress note documented the Resident kept asking for a cigarette every 20 minutes. When the nurse told the resident it was too early and that he was given a cigarette 20 minutes ago, the resident got really upset and started to yell saying that the nurse is not being fair. Resident forgets when he smokes and keeps coming back asking for more cigarettes every 20 minutes. A behavior progress note dated 7/18/2020 revealed the resident became agitated and aggressive when he has not received his cigarettes. He asked frequently (for cigarettes) even if he received one 10 minutes before. The note documented his cigarettes ran out on 7/18/2020. He became mad and was verbally as well as physically aggressive and wanted to leave the building. The nurse wrote, Every time is hard for him to handle the situations. We can keep distance from him. He is also mean to other helping staff. A behavior progress note dated 7/19/2020 documented the resident became agitated and combative when asking for a cigarette. The nurse wrote, We cooperate with him by providing cigarettes every hour. Other residents also complained about his latest behavior. His behavior has changed day by day. He wanted to discharge somewhere. A behavior progress note dated 7/21/2020 read, approximately 8:00 p.m., the resident walked out of his room without the walker. When the nurse advised the resident to use a walker for safety, the resident yelled at the nurse stating I can walk without the (expletive) walker. The resident walked past the dining hall and sat in the front room. When the nurse opened the front door to let the X-ray vendor out, the resident pushed and hit the nurse. When staff tried to stop him he forced himself out the door. After a couple minutes, the nurse and CNA (certified nurse aide) were able to convince him to come in. Resident is very agitated regarding cigarettes. Since the resident is getting too aggressive, this nurse gave half a packet of cigarettes to the resident. A behavior progress note dated 7/29/2020 documented the resident was not compliant with cigarette storage. At 3:00 p.m., the resident dropped the empty cigarette storage case at the nurses desk. When this nurse ask resident what was wrong, resident stated this is stupid and I took all the cigarettes out. Since then, the resident has been asking for a cigarette every 15 minutes. When the nurse explained to the resident that he was given all his cigarettes, the resident got really upset and called this nurse a liar. The nurse wrote, Resident's behavior is escalating every day. Needs psych meds evaluated. A behavior progress note dated 7/30/2020 at 8:12 a.m. documented a therapist, observed the resident attempting to take cigarettes from others and became aggressive when he was denied one. A behavior progress note dated 7/30/2020 at 1:20 p.m. documented the resident was observed wandering the hallway asking frequently for a cigarette but not forced. On 8/1/2020 a behavior progress note documented the resident had been out on the smoking patio and when he returned the nurse discussed with him about giving his cigarettes and lighter to the nurse to keep in the med cart. The resident claimed that he never heard of the rule that he couldn't keep cigarettes and lighter in the room since he has been here. He was reminded that he always came to the nurses to ask for a cig when he wanted to smoke. The resident responded, Well, that's too bad. You're not getting my lighter. The resident was made aware that failure to comply with rules might have consequences. On 8/10/2020 a behavior progress note documented the resident came out of the room with a walker and approached this nurse for cigarettes. Nurse stated that he did not have any and that the resident would have to ask the finance office if he had money to purchase them. Upon offer by the nurse, the resident refused his medication. He stated, I don't want any pills. The nurse noted, but drank the water offered. The resident then stood up and stated, I don't need this (his walker) anymore, do I? and proceeded to walk without it. The nurse encouraged the resident to use the walker. The nurse wrote, the resident appeared irritated with the nurse and responded No, I don't need it and walked off with imbalance to find the finance office. Resident is currently asking anyone who is close if they have cigarettes or where the finance office is and appears irritated. b. Nursing progress notes A nursing progress note dated 8/6/2020 documented, Resident continues to request a cigarette every 15-20 minutes. A nursing progress note dated 8/12/2020 documented, Resident much calmer tonight. This nurse smelled cigarette smoke in the resident room while doing rounds at 2300 (11:00 p.m). Roommate said the resident was smoking in the room. Resident was sleeping soundly at the time. Removed lighter from resident's bed side table. The progress notes indicated the resident was smoking more cigarettes than he normally did. The increase in smoking/chain smoking resulted in the resident running out of cigarettes and the money to buy more. Staff attempted to reason with him and have him ration his cigarettes to avoid running out. The resident was given a box with a timer to help him remember to wait for the scheduled cigarette break. Staff purchased cigarettes for the resident, with their own money, to prevent the resident's aggressive behavior. Although staff attempted interventions, they were not effective. The root cause of the increased smoking was not determined and interventions attempted by staff were not effective. D. Wandering with elopement care plan The elopement care plan initiated on 4/24/2018 and revised 7/22/2020 showed the resident was an elopement risk related to ETOH dementia. With consent from legal guardian, the resident's wander guard is placed on his FWW (four wheeled walker) due to history of removing the wander guard from his body. The goal initiated 7/22/2020 with a target date of 9/21/2020 documented the resident's safety will be maintained through the review date. The resident will demonstrate happiness with daily routine through the review date. The resident will not leave the facility unattended through the review date. The interventions initiated on 4/24/20 and documented as revised on 7/23/2020 included the following: Assess for fall risk; Check placement and function of safety monitoring device every shift; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Observe for fatigue and weight loss; Observe location at regular and frequent intervals; Document wandering behavior and attempted diversional interventions; Offer emotional and psychological support; Orient resident to environment; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; and Reorient/validate and redirect the resident as needed. 1. Progress notes A nursing progress note dated 7/22/2020 documented the nurse Placed wander guard on left wrist, explained rationale to resident and he is agreeable to wearing it. A care conference note dated 7/23/2020 read in pertinent part, IDT (interdisciplinary team) met to review recent increase in possible elopement type behaviors. Behaviors are tied to cigarettes or lack thereof. We supplied cigarettes and stored them in the north med room for easy access 24/7. Wander guard placed on, he removed it immediately. Wander guard placed on the walker which he does not use all the time. On 15 minute checks. A behavior progress note dated 8/7/2020 read, Received call from exiting employee stating resident has pushed door open & is outside. Staff unable to successfully redirect resident back inside facility. Resident intends to walk to convenience store across the street to purchase cigarettes. Staff x2 (two) accompanied resident across the street, while contacting 911 for assistance with encouraging resident to return to facility. 911contacted at 1635 (4:35 p.m.) per staff member. Resident inside facility at 1657 (4:57 p.m.) Resident placed on 1:1 (one-to-one) supervision. Resident removed the wanderguard. Wanderguard was replaced upon return to the facility. A behavior progress note dated 8/7/2020 documented the resident walked out of the front door without consent. He became agitated, aggressive and waited for somebody to pick him up. The nurse documented the resident was upset about staying in the building and tried to leave. He was redirected but refused. He became aggressive back in the building and pushed the walker into a staff person. His walker fell on the ground and he lost his balance and fell on the floor. He refused a physical assessment and vital signs. His PCP (primary care physician) was notified. The PCP wrote a new order for [MEDICATION NAME] (antipsychotic) 1mg (milligram) and CBC (complete blood count)/CMP(comprehensive metabolic panel)/Ammonia (lab) on Sunday. A behavior progress note dated 8/11/2020 documented the Resident used to participate in a scheduled smoking program without incident. He also allowed wanderguard placement. Now he does neither. We have notified PCP who ordered labs, reviewed meds, and added new med, [MEDICATION NAME]. We will continue to seek placement in secured male unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	4685 BASELINE RD BOULDER, CO 80303

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 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) but have been unsuccessful with finding placement. He is on 15 minute checks and staff accompanies him as needed. A nursing progress note dated 8/12/2020 documented the resident was at the front door pushing it open, alarm sounding. Staff were unable to redirect him and he attempted to punch the nurse. The NP (nurse practitioner) was called and the resident's [MEDICATION NAME] was increased to 1.0 mg Q (every) HS (night). E. Other documentation 1. PASRR Level II The resident's Colorado PASRR Level II Notice of Determination for MI (mental illness) dated 11/30/17 revealed the Explanation of Identified Rrisks section documented the resident had a history of [REDACTED]. It was recommended to keep him in a controlled environment; to monitor for increased level of depression, to keep the items that he could use to harm himself out of his reach, restrict his access to alcohol and individual counseling, including relapse prevention counseling. The Provision of Nursing Facility Specialized Services section recommended the following: -The resident should be encouraged to attend and participate in any activities or hobbies he enjoys to increase socialization and community participation: -Nursing facility to encourage and coordinate contact with the resident's family members, friends, providers and other supports in the community as permitted. -Nursing Facility staff should provide ongoing evaluation and documentation of his mood participation in care, treatment, medication management and psychiatric stability. -Any significant change in condition, increase or decrease in behaviors or symptoms shall be reported to the attending physician, psychiatrist, and designated OBRA-PASRR for further evaluation as indicated. The mental health specialized service section read, Since client appears to have only mild neurocognitive disorder, he can benefit from individual counseling 2-4 (two to four) times a month with emphasis on coping with depression, relapse prevention, and smoking cessation. The record did not include documentation of a psychiatric evaluation when the behaviors were first noted to increase in the beginning of June 2020. -Evidence of counseling or psychiatric evaluation was verbally requested from the DON during the interview conducted on 9/16/2020 at 2:55 p.m. No documentation was received. 2. Physician physical examination The resident's comprehensive physical examination dated 7/14/2020 documented the resident's Behaviors stable with no reported suicide ideation. The physician documented the resident had a personal history of self-harmwhich he showed as stable. The plan was to Monitor depression, counseling. The goal was for the resident to show no signs of a risk to harm self or others by goal target date 03/31/2021. The physician noted this was in progress. 3. Behavior documentation The residents electronic medication and treatment administration records (EMAR/ETAR) from 6/1/2020 through 8/21/2020 were reviewed. The administration records included an entry started 1/14/19 and discontinued on 8/21/2020. The order instructed staff to observe for the following behavior: inappropriate touching, language, interaction. The side effects staff were instructed to observe for were: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Staff were to document Y for behavior present and write progress notes every shift. -The EMAR/ETARs failed to show staff monitored depression as ordered by the physician. Further, documentation showed no evidence the resident received counseling prior to being placed on an M1 hospital hold on 8/15/2020. IV. Staff training A behavior training dated 2/12/2020 documented basic and generic behavior management training that defined behavior; types of behaviors common in long term care settings such as agitation, anxiety and non-compliance; causes of behavior; techniques; and communication of behavior. The training was completed five months prior to the acute behavior the resident exhibited from 7/6/2020 to 8/21/2020 and did not include person centered interventions specific to the resident behavior needs. A validation therapy training, dated 8/19/2020, read, it was a way to to approach older adults, those with memory loss,confusion, disorientation, and other symptoms of dementia. The basic idea is that people are unique and must be treated as individuals; Older adults may have unresolved issues that drive their behaviors and emotions; The way we respond to these behaviors can either make them worse or help resolve them; Focus on helping your resident work through these emotions and behaviors; Embrace their situation and help them, do not fight them; and Validation therapy is a healthy way to redirect into a safer situation or activity/behavior. The training documented, Validation therapy is a method of therapeutic communication which can be used to connect with someone who has moderate to late-stage dementia. It places more emphasis on the emotional aspect of a conversation and less on the factual content, thereby imparting respect to the person, their feelings and their beliefs. Our goal is to keep our residents safe, well taken care of, and respected. Validation therapy is a tool to help us achieve that. - The training did not include person centered interventions specific to the resident behavior needs. V. Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated the resident was having increased behaviors. He was running into traffic out of the facility and staff had to hold up traffic for his safety. The police were called and he was placed on an M1 hold. The SSD stated anyone with dementia [DIAGNOSES REDACTED]. The physician was contacted to determine the need for M1 hold. We determine if there are interventions to put in place prior and what was tried. She said the resident had severe mental health issues. The NHA said something acute was happening with him. He had paranoia, was chain smoking, and was unsafe to be in the building. She said they wanted to get to the bottom of this. When he was sent back from the hospital he objected. When he came back on 8/21/2020, he was quarantined and required a one-to-one staff supervision. He broke out a window and was stepping on the glass. He was sent out on another M1 hold. The DON was interviewed on 9/16/2020 at 2:55 p.m.The DON stated, the resident's target behaviors were agitation, verbal and physical aggression and elopement. She said his behavior started to increase in his behaviors in June 2020 but was more noticeable in July 2020. Prior to the recent behaviors, he just walked around and asked for cigarettes and then went to smoke every two hours. He started to increasingly ask for cigarettes and then forgot he already asked. He got aggravated and mad. He was verbally aggressive to staff and a couple of times physically aggressive hitting them with his walker. We figured out a way for him to have cigarettes more often. They were put in a box in which he had access to. She said it did not work; he was still agitated with the box. When his behaviors started to increase he then had it in mind he had to leave. He would go outside because he said he had a friend that was going to pick him up or he had to go to the airport. She said it was a friend of his from [AGE] years ago. She said they tried to find him but were not able to. The DON stated the resident cut off his wander guard. She said she did not know how he did it and he would not tell them. They searched his room but could not find anything he would be able to use to cut it off. She said he would not tell us where he would put it either and had to buy new ones. She said they placed it on his walker then he started leaving his walker and not using it. She said the wanderguard was checked by staff every shift. Staff documented the wander guard check on the EMAR (electronic medication administration record). She said, at first he was able to redirect, then it became harder. He figured out how to open the front door by pushing on it for 15 sec. When the alarm went off, staff followed and redirected him. When he was in the parking lot on 8/15/2020 he was not able to be redirected. She said he had to be sent out to the hospital on a M1 hold. When he returned on 8/21/2020 he was agitated and threw a bedside table at a window to get out. He refused treatment from the nurse. The medical director was called and he was put on a second M1 hold. The NHA and the DON were interviewed a second time on 9/17/2020 at 3:06 p.m. The NHA stated a one to one was started on 8/1/2020 to have someone with him to occupy him but sometimes it was not needed. A CNA (certified nurses aide) was assigned to him only when he was exit seeking. Prior to the increase in his behaviors, he wandered within the building usually from his room to the smoking area and back. He would go have a cigarette and then go back to his room. The behaviors we saw were more like an anxiety, a need to go somewhere. She said he used a walker as a weapon to hit staff and he punched staff. When anyone would get too close he would physically react. She said they used 15 minute checks as staff were accustomed to do it regularly for his sexually inappropriate behaviors. The DON said, when she sent him out the first time 8/15/2020 they ruled out medical causes at the hospital. They thought he had a UTI (urinary tract infection) and was on antibiotics when he moved from the hospital to the psychiatric facility. She said he did not have a UT
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide one (#1) of three out of seven sample residents with medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically, the facility failed to provide sufficient and appropriate social services to meet the resident's needs. Cross-reference F657 for care planning and F744 for treatment and services for dementia care. Findings include: I. Facility policy and procedures The Behavioral Health Management policy, dated March 2018, was provided by the nursing home administrator via email on 9/17/2020 at 2:37 p.m. The policy read in pertinent part, Residents receive behavioral health care and services, including those residents diagnosed with [REDACTED]. In addition, residents whose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065222	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOULDER MANOR	**4685 BASELINE RD BOULDER, CO 80303**

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 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 11) assessment did not reveal or who do not have a [DIAGNOSES REDACTED]. The facility makes reasonable attempts to secure professional behavioral health services, when needed.The resident's behavioral health needs are assessed, monitored, and evaluated on an ongoing basis to review the effectiveness of the interventions in place. The care plan is reviewed at least quarterly, annually, and with significant change in status. Alternative approaches to care are updated or added, if necessary, to address the resident's behavioral health status. II. Resident #1 A. Resident status Resident #1, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/14/2020 minimum data set (MDS) assessment revealed the resident did not participate in the brief interview for mental status (BIMS) therefore, a score was not obtained. The staff assessment for mental status documented the resident had memory problems and was moderately impaired for decision making. He was independent and required set up only for transfers; supervision with set up only for bed mobility, dressing, eating, and toileting; and supervision and one person physical assistance for personal hygiene. His behaviors included hallucinations and delusions; he engaged in verbal behavior one to three times a week; physical behavior four to six times a week; rejected care one to three days a week and wandered one to three days a week. He used a wander/elopement alarm daily. His activity preferences were not assessed and the PHQ-9 (Patient Health Questionnaire) was not completed. B. Record review The Colorado preadmission screening and resident review (PASRR) Level II Notice of Determination for Ml (mental illness) dated 11/30/17 revealed the Explanation of Identified Rrisks section documented the resident had a history of [REDACTED]. It was recommended to keep him in a controlled environment; to monitor for increased level of depression, to keep the items that he could use to harm himself out of his reach, restrict his access to alcohol and individual counseling, including relapse prevention counseling. The Provision of Nursing Facility Specialized Services section recommended the following: -The resident should be encouraged to attend and participate in any activities or hobbies he enjoys to increase socialization and community participation: -Nursing facility to encourage and coordinate contact with the resident's family members, friends, providers and other supports in the community as permitted. -Nursing Facility staff should provide ongoing evaluation and documentation of his mood participation in care, treatment, medication management and psychiatric stability. -Any significant change in condition, increase or decrease in behaviors or symptoms shall be reported to the attending physician, psychiatrist, and designated OBRA-PASRR for further evaluation as indicated. The residents electronic medication and treatment administration records (EMAR/ETAR) from 6/1/2020 through 8/21/2020 were reviewed. The administration records included an entry started 1/14/19 and discontinued on 8/21/2020. The order instructed staff to observe for the following behavior: inappropriate touching, language, interaction. The side effects staff were instructed to observe for were: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Staff were to document Y for behavior present and write progress notes every shift. -The EMAR/ETARs failed to show staff monitored depression as ordered by the physician. Further, documentation showed no evidence the resident received counseling prior to being placed on an M1 (emergency mental health hold procedure) hospital hold on 8/15/2020. -The behavior documentation revealed staff did not collect behavioral data according to the behaviors that were exhibited by the resident. The mental health specialized service section read, Since client appears to have only mild neurocognitive disorder, he can benefit from individual counseling 2-4 times a month with emphasis on coping with depression, relapse prevention, and smoking cessation. -The record did not include documentation of a psychiatric evaluation when the behaviors were first noted to increase in the beginning of June 2020. Evidence of counseling or psychiatric evaluation was verbally requested from the DON during the interview conducted on 9/16/2020 at 2:55 p.m. No documentation was received. The August 2020 CPO documented physician orders [REDACTED]. Both orders were discontinued on 8/21/2020. The electronic record failed to show evidence the resident received counseling or psychiatric services, specifically during his acute behavioral episodes, to diagnose and assist staff with mental health and behavioral interventions. -Documentation of counseling and psychiatric services was requested from the DON on 9/16/2020. No further information was received. C. Staff interviews The NHA and the social services director (SSD) were interviewed on 9/16/2020 at 12:15 p.m. The NHA stated the resident was having increased behaviors and he was placed on an M1 holds at the hospital. The SSD stated anyone with dementia [DIAGNOSES REDACTED]. The physician was contacted to determine the need for M1 hold. We determine if there are interventions to put in place prior and what was tried. She said the resident had severe mental health issues.