STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents, affecting two (#1 and #8) residents reviewed of the nine sample residents. Specifically, the facility failed to: -Adequately meet Resident #1 ' s need for supervision. Resident #1 was severely cognitively impaired and independently ambulatory with recent [MEDICAL CONDITION] activity. Record review revealed he consistently engaged in exit seeking, some days constantly, frequently urinated and defecated in his room and common areas of the facility, as well as engaged in other unsafe behaviors, such as taking food off residents ' plates and dirty plates, putting metal items in electric outlets, and wandering into other residents ' bedrooms. The facility failed to provide Resident #1 the level of supervision his condition and behaviors required. This failure created the likelihood of serious adverse outcome to Resident #1 and other facility residents if not immediately corrected. The facility also failed to identify and care plan Resident #8 ' s risk for wandering and eloping and initiate interventions for the resident ' s safety. Findings include: I. Immediate jeopardy A. Situation of immediate jeopardy Resident #1, severely cognitively impaired and independently ambulatory, with recent [MEDICAL CONDITION] activity, exhibited behaviors likely to cause serious adverse outcomes, including attempting to elope from the facility over a dozen times and attempting to place metal feeding utensils inside electrical outlets. The resident also had a grand mal [MEDICAL CONDITION] on 4/4/2020 while in the smoking area, which had the potential for serious adverse outcome if staff had not witnessed the [MEDICAL CONDITION] or if the resident had been in a location where there had not been any witness due to his frequent elopement attempts from the facility. Resident #1 ' s condition and behaviors and failures in the facility ' s response, created the likelihood of serious adverse outcome if the facility ' s response was not immediately corrected. B. Imposition of immediate jeopardy On 4/22/2020 at 8:36 p.m., the nursing home administrator (NHA) was informed the facility failed to provide supervision to a known eloping resident with poor safety awareness, which created a situation of immediate jeopardy with the potential for serious adverse outcome for Resident #1. C. Facility response to immediate jeopardy On 4/23/2020 at 5:40 p.m., the regional director of operations (RDO) submitted a final abatement plan (draft #5) to the Colorado Department of Public Health and Environment (CDPHE) to remove the immediate jeopardy situation. The abatement plan read: Resident #1 (#2573) was reassessed for wandering or elopement on 4/22/2020 and found to still be at high risk for elopement. The resident was placed on one to one at 8:55 p.m. on 4/22/2020 to ensure he did not exit the building unaccompanied. Staff will be assigned the one to one observation/attendance as their sole responsibility for the shift. Shifts will vary from eight hours to twelve, determined by availability, with staff in house or outside staffing agencies. Interventions for Resident #1 will include encouraging him to come back into the building gently motioning him to follow, walking with him outside, offering snacks or a coke, engaging him in games. Resident #1 will remain one to one supervision and assistance until he is transferred to another facility. Education with regards to elopement and wandering and constant supervision for Resident #1 current staff and any agency staff with regards to supervision of Resident #1 and elopement interventions, will occur prior to them starting their next shift, done as they are assessed for entry into the building. An education print out will be provided to current staff and agency staff upon their arrival for them to keep on their person, as well as education they will sign attesting to their knowledge of the following: The definition of wandering and elopement Who has wander guards Interventions for Resident #1 and need for constant supervision Plausible interventions for other residents who are at risk for wandering or eloping All exits for the building were assessed on 4/22/2020 to determine if there were areas of vulnerability for residents at risk to exit. D. Removal of the immediate jeopardy: On 4/23/2020 at 6:00 p.m. the NHA and RDO were notified the immediate jeopardy had been removed based on review of the facility ' s abatement plan. However, deficient practice remained at an E level. II. Resident #1 A. Resident status Resident #1, age less than 65, admitted [DATE]. According to the April 2020 computerized physician orders [REDACTED]. According to the 2/6/2020 minimum data set (MDS) assessment, the resident ' s cognitive function was severely impaired with a brief interview for mental status (BIMS) score of two out of 15. The resident had behaviors not directed toward others including physical symptoms such as disrobing in public, urinating and defecating in public, and wandering one to three days during the assessment period. The resident was independent with walking in the room and corridor. He required minimal assistance of one person for dressing, toilet use and personal hygiene. According to the April 2020 computerized physician orders [REDACTED]. Review on 4/30/2020 of the behavior monitoring record revealed for February 2020, March 2020 and April 2020, the resident was to be monitored for exit seeking behaviors every shift. B. The facility was aware Resident #1 exhibited behaviors (exit seeking, urinating and defecating throughout the facility, digging through garbage, eating off dirty plates, and attempting to put metal items in electric outlets) which placed him as well as other facility residents at risk for serious adverse outcomes. Nursing progress notes from June 2019 to April 2020 documented increasing incidents of exit seeking, inappropriate urination and defecation, and instances of aggressive and inappropriate behaviors toward other residents and staff. 1. June 2019 to January 2020 progress and interdisciplinary notes documented increased exit seeking, unsafe and intrusive wandering, unsanitary and aggressive behaviors with an identified need beyond line of sight supervision, to constant one to one supervision in mid-January, due to agitation and physically aggressive, confrontational and intimidating behavior toward residents and staff. -A 6/21/2019 nursing progress note revealed the resident was found outside smoking after his wander guard alarm alerted staff that he had exited the facility. -A 8/2/2019 interdisciplinary team (IDT) risk management progress note revealed the resident was found walking down the street by staff on 8/1/2019 at 6:46 p.m. The note read staff checked his wander guard which was functioning. He was reminded he cannot leave the facility without supervision. -An 11/19/2019 nursing progress note revealed the resident defecated in the sink and smeared feces on the bookcase, books, floor and clothing. The note read he was approached by three staff members after being resistive to care without success. -An 11/23/2019 nursing progress note revealed the resident was arguing with another resident who accused him of hitting her in the mouth. The note read the residents were separated and Resident #1 was provided one to one supervision until 11/24/2019. The note further read the resident was exit seeking, going outdoors multiple times an hour, often difficult to redirect and resistive to personal care. The care plan was updated to include: redirect and assist the resident away from confrontational situations. -An 11/24/2019 nursing progress note revealed the resident had multiple exits outdoors, greater than 16 in a shift with occasional verbal outbursts when redirected and continued resistance to personal care. -An 11/26/2019 nursing progress note revealed the resident was exiting outdoors literally every three to five minutes, was difficult to redirect and became agitated with verbal outbursts. It indicated he walked through the dining room, taking food off other residents ' plates and urinated on the floor in his room. It also revealed the resident took a newspaper out of another resident ' s hands and hit them on the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) head with the newspaper. The care plan was updated to include: assist the resident to a quieter calmer area of the living environment to decrease stimulation. -An 11/27/2019 nursing progress note revealed the resident repeatedly exited doors and became increasingly difficult to redirect indoors. It read he wandered through the dining room taking food and belongings from other residents. The care plan was updated to read: keep the resident in line of sight while out of the room related to history of aggression towards other residents and seek alternative placement with memory care focus, decreased stimulation and a secure unit. -An 11/28/2019 nursing progress note revealed the resident repeatedly exited the building and was difficult to redirect back indoors. It indicated he was urinating on the floor, was confrontational and quick to anger. -An 11/29/2019 nursing progress note revealed the resident did not sleep during the night shift, wandering and exit seeking and was difficult to redirect. -An 11/30/2019 behavior progress note revealed the resident defecated on the floor in his room and smeared it around on the floor. -A12/4/2019 nursing progress note revealed the resident was exiting out the door to the smoking patio throughout the shift but could be redirected back into the building. -A 12/8/2019 nursing progress note revealed the resident was found without pants on in his room with urine on the floor and feces on the bed and then wandered outside without pants. The note read the resident went out the main door and the door at the end of the hallway, setting off the alarms. -A 12/10/2019 nursing progress note revealed the resident exited outdoors multiple times during the shift and was redirected back into the building after multiple attempts. The note further read the resident spread feces throughout his bedroom floor with his feet and urinated in the hallway and was resistive to care. -A 12/16/2019 nursing progress note revealed the resident kept going outside without socks. -A12/25/2019 nursing progress note revealed the resident frequently walked outdoors by the activities area, the front door, the smoking area and Maple Hall. It read he was difficult to redirect and required one to one monitoring for a majority of the shift to prevent him from confronting other residents. -A 12/28/2019 nursing progress note revealed the resident was continually walking out the smoking area door, with no coat, socks or shoes on. It indicated he continually attempted to go out locked/alarmed doors, setting off alarms on Maple hall, the sun room, the smoking area, activities area and the front door, becoming verbally aggressive and physically intimidating with raised fists, raised voice, and cursing. The note revealed the resident opened other residents ' doors, wandered in and upset them. The note further read he rummaged through the garbage, ate leftover food off dirty dishes and required constant monitoring due to exit seeking, setting off door alarms, and wandering into other residents ' rooms. -A 12/29/2019 nursing progress note revealed the resident was awake the entire night shift, wandering into other residents ' rooms and exit seeking, setting off alarms. -A 12/31/2019 nursing progress note revealed the resident was continuously exit seeking and walking outdoors without socks and shoes on. It read the resident was taking food and beverages off other residents ' tables and became angry and combative when redirected. -A 1/1/2020 nursing progress note revealed the resident had continuous exit seeking during the shift wearing only a soiled brief. It indicated he defecated in the sink and urinated in the hall, allowing staff to assist with personal care after multiple approaches. -A 1/2/2020 nursing progress note revealed the resident had continual exit seeking to the smoking patio and twice through alarmed exit doors. It indicated he urinated on the floor in his room and was difficult to redirect. -A 1/4/2020 nursing progress note revealed the resident was continually exit seeking but was able to be redirected back into the building. The note read he urinated on the floor of the chapel and his room and he was taking food, plates, utensils and glasses from other residents ' tables. -A 1/7/2020 nursing progress note revealed the resident had been urinating on the foosball table in the chapel and stuffed his sandwich in the hole on the table. -A 1/9/2020 nursing progress note revealed the resident was repeatedly exit seeking and was difficult to redirect. -A 1/10/2020 nursing progress note revealed the resident was exit seeking throughout the shift but was easily redirected without behaviors. -A 1/11/2020 nursing progress note revealed the resident was exit seeking during the shift and was difficult to redirect at times. -A 1/12/2020 nursing progress note revealed the resident continued with constant exit seeking, triggering alarmed doors which woke other residents. It indicated the resident wandered into other residents ' rooms, even when the doors were closed. The resident continually exited through the smoke area door, triggering the alarm with no coat or footwear on in cold weather. It indicated the resident dug through the garbage and ate leftover food off dirty plates. The resident urinated on a sit to stand lift on Willow hall and on the floor in the chapel. It indicated the resident was ambulating throughout the facility without any clothes on and was difficult to redirect, becoming agitated, angry and physically intimidating, raising his fists while approaching the staff at a close proximity. The note read the resident required constant one to one supervision to ensure he did not exit the building and to ensure his safety as well as the safety of other residents. -A 1/13/2020 nursing progress note revealed the resident had continuous exit seeking with no shoes on and defecated in the smoking area then wandered in the hall wearing soiled pants. The note read the resident was resistive to care. -A 1/15/2020 nursing progress note revealed the resident was constantly exiting through the smoking area door and end of Maple hall, triggering the alarms, without a coat, socks or shoes. The note read he urinated in various locations on Willow hall three times and in the chapel once. The note further read, the resident required constant one to one to ensure he did not exit the building and to ensure his safety as well as the safety of other residents; however, staff was not always available to provide one to one needed to shadow the resident as he wandered, was exit seeking and to make sure he did not urinate or defecate in inappropriate places throughout the facility. Another nursing progress note on 1/15/2020, read staff witnessed the resident attempting to place metal silverware inside electrical outlets and were able to redirect him. The staff also witnessed the resident drinking directly from the pitchers on the breakfast drink cart and pouring artificial sweetener packets directly into his mouth. It indicated the resident became easily agitated, physically aggressive and intimidating when attempting to redirect. -A 1/16/2020 nursing progress note revealed the resident had frequent exit seeking, as well as urinating in the hallway, room, chapel and lobby and defecating in his room. It read he was walking in the hallways naked and was resistive to care. 2. February 2020 to April 2020 progress and IDT notes revealed Resident #1 continued to exit seek frequently, continuously, although the behavior monitoring records (reviewed 4/30/2020) for February 2020, March 2020 and April 2020 documented no behaviors and a 2/2/2020 Wandering/Elopement Risk Assessment assessed the resident at a moderate risk for wandering. In addition, the resident ' s unsafe behaviors noted above also continued. -A 2/5/2020 nursing progress note revealed the resident had frequent exit seeking, setting off alarms, walking in the halls at a rapid pace with a forward leaning gait. -A 2/6/2020 nursing progress note revealed the resident had frequent exit seeking. -A 2/14/2020 IDT risk management progress note revealed the resident had a behavior of participating in poor eating etiquette during dining meal times by reaching in other residents ' plates on 2/13/2020 at 5:50 p.m. The resident was to receive meals prior to dining meal times to provide a calmer environment. -A 2/19/2020 social service progress note revealed the resident was observed attempting to exit seek and was able to be redirected. -A 2/21/2020 behavior progress note revealed the resident was continuously exit seeking and urinating on the floor in his room. He was redirected with little success. -A 2/23/2020 nursing progress note revealed the resident was observed sitting on the floor in the dining room and then laying down with twitching motions noted to his upper extremities that stopped after 15 to 20 seconds. -A 2/25/2020 nursing progress note revealed the resident was attempting to go outside unattended without shoes or a jacket, but was easily redirected. -A 2/28/2020 behavior progress note revealed the resident had been wandering throughout the facility and had gone out several times setting off the alarms. It indicated he was voiding on the floor in public areas then laying down on the wet floor. He was difficult to redirect and would get combative with the staff. -A 2/28/2020 nursing progress note revealed the resident continued to do in and out of doors, urinated and defecated on his bedroom floor, and required frequent monitoring and guidance by multiple staff. -A 3/7/2020 nursing progress note revealed the resident was wandering in the hallways and was difficult to redirect away from the sun room where he attempted to go out the door. -A 3/8/2020 nursing progress note revealed the resident was wandering the hallways onto the other unit and exited several times. It indicated he urinated on his bedroom floor and was difficult to redirect. -A 3/10/2020 nursing progress note revealed the resident had repeated exit seeking and voided in the chapel. -A 3/11/2020 nursing progress note revealed the resident had active exit seeking in the early evening. The note read he exited onto the smoking patio 12 times in one hour. -A 3/13/2020 nursing progress note revealed the resident wandered in the hallways, urinated on his bedroom floor several times and defecated in inappropriate areas. -A 3/14/2020 nursing progress note revealed the resident went outside in the smoking area walking the fenced area and when staff went to recheck on the resident, he was no longer in the fenced area. It indicated the administrative staff immediately went and searched the grounds and escorted the resident back to the facility. The wander guard was in place and working properly. The resident was placed on safety checks and was to be kept in the facility or monitored outside with staff at all times. -A 3/15/2020 nursing progress note revealed the resident continued to exit seek but was able to be redirected. -A 3/16/2020 nursing progress notes revealed the resident continued on frequent checks due to elopement. It indicated the resident continued to make several attempts to exit the building going out the alarmed door in the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) room and the door to the smoking patio but was able to be redirected without any issues or concerns. -A 3/18/2020 IDT risk management progress note revealed the resident was put on 15 minutes safety checks and when he was sleeping, staff were to sit in the hall to monitor the door to his room to ensure the resident did not get out of the facility. It indicated the resident was redirected when he tried to go outside or staff went outside with the resident. -A 3/21/2020 nursing progress note revealed the resident defecated on his bedroom floor. -A 3/23/2020 nursing progress note revealed the resident attempted to leave out the back door near the sunroom, causing the alarm to go off. -A 3/28/2020 nursing progress note revealed the resident was going in and out of the smoking patio multiple times with frequent visual monitoring being done during the shift. -A 4/4/2020 nursing progress note revealed the resident had a grand mal [MEDICAL CONDITION] about one and a half minutes while out of the smoking patio with residents and a nurse. -A 4/6/2020 nursing progress notes revealed the resident was up and pacing the television room and tried to go out the smoker door but was able to be redirected. -A 4/6/2020 behavior progress note revealed the resident exited the smoke area and proceeded to walk down the road. The note read staff was able to retrieve the resident and return to the building without difficulty. -A 4/7/2020 nursing progress note revealed the resident had door seeking behavior, wandering on the halls and lying on the floor. -A 4/11/2020 nursing progress noted revealed the resident had exit seeking behavior during the shift and wandering the halls without pants on. -A 4/12/2020 behavior progress note revealed the resident had been very restless and had elopement behavior the entire shift. It read the resident attempted to exit through different doors several times but was able to be redirected. -A 4/13/2020 nursing progress note revealed the resident had been trying to exit, setting off the door alarms multiple times. It indicated that he took his pants off in the hallway. -A 4/14/2020 nursing progress note revealed the resident continued to exit seek numerous times throughout the day shift setting off different alarms throughout the facility. The nurse continued to assist the resident back into the facility. -A 4/18/2020 nursing progress note revealed the resident continued to exit seek numerous times throughout the day setting off alarms in different areas of the facility. Staff were able to redirect the resident back into the facility. -A 4/19/2020 nursing progress note revealed the resident had been setting door alarms off by continued door seeking behavior throughout the night. -A 4/20/2020 nursing progress note revealed the resident was wandering the halls, door seeking through the night setting the door alarms off. -A 4/21/2020 nursing progress notes revealed the resident exited the building by the smoke area and attempted to exit the courtyard area but he was able to be redirected back into the building without altercation. C. Failure to meet Resident #1 ' s need for supervision prior to 4/22/2020 at 8:36 p.m. and notification of immediate jeopardy, creating the likelihood of serious adverse outcome for Resident #1 and other facility residents. 1. Failure to develop and implement effective interventions June 2019 to January 2020 to keep Resident #1 and other facility residents safe from serious adverse outcomes. Record review revealed prior to November 2019, Resident #1 did not have interventions to address his wandering and exit seeking behavior, except for his use of a wander guard. While he had a care plan to address his potential to display unprovoked verbal and physically aggressive behaviors toward others and his episodes of smearing feces and defecating in inappropriate places, there were no interventions to address these behaviors. In November 2019, when Resident #1 ' s exit seeking significantly increased (going outdoors multiple times an hour, going outdoors greater than 16 times per shift, going outdoors literally every three to five minutes, his care plan was updated (line of sight while out of room); however, redirection was the most frequently noted intervention. Yet, neither line of sight nor redirection was effective, as evidenced by subsequent notes in December 2019 and January 2020 (see above) of the resident continuously exit seeking, often without appropriate clothing (no coat or footwear in cold weather). Staff documented ((12/25/19, 1/12/19, 1/15/19) that the resident required one to one monitoring/supervision and/or constant one to one monitoring, but noted in one entry that staff was not always available to provide one to one to shadow Resident #1 as he wandered. While an 11/27/19 note had documented an alternative placement would be pursued, the facility was unable to find appropriate placement and the staff reported one to one was not always available. In addition, there was no evidence the resident ' s behavior care plan was updated with interventions to address his unsafe, unsanitary behavior of defecating and urinating in inappropriate places and opening other residents ' doors and wandering in, behaviors that created a safety risk for both Resident #1 and other facility residents. There was no evidence that line of sight supervision was effective in minimizing these incidents. 2. Failure to develop and implement effective interventions February 2020 to April 22, 2020 to keep Resident #1 and other facility residents safe from serious adverse outcomes. a. Failure to implement plan to supervise Resident #1 in the courtyard as planned or to keep the resident in line of sight (see administrator (NHA) interview below) Record review revealed Resident #1 ' s care plan was updated on 3/14/2020, after the resident left the fenced-in smoking area. It read, The resident will not be outside the fenced courtyard unsupervised. However, a behavior progress note dated 4/6/2020 (see above) revealed the resident exited the smoking area and proceeded to walk down the road before he was retrieved by staff. Observations on 4/22/2020, from 4:35 p.m. to 5:00 p.m. also revealed Resident #1 was not supervised in the courtyard as planned. Specifically: On 4/22/2020 at 4:35 p.m., Resident #1 was not found in his room. The Assistant Director of Nurses (ADON) was observed walking from the 100 hall toward the common/television (TV) area. RN #1 was standing at a medication cart in the common area, with her back to the door that exited to the outside smoking area. No other staff were in the common area prior to 4:40 p.m. as the surveyor exited through the door to the smoking area. The door was not locked and did not alarm when opened. Observations revealed three residents sat at separate tables, smoking. Beyond these residents and off to the left of a walkway, Resident #1 sat on the ground in front of a bench, leaning forward with his forehead resting on a concrete flower pot and his arms at his sides. There was no staff member with him. His left leg was bent underneath him and his right leg was bent at the knee and extended out to his right. He was wearing a long sleeved shirt, pants, and a sock on his left foot. His right foot was bare. His speech was incoherent and he was unable to say why he was sitting on the ground or if he was injured. At 4:41 p.m., the ADON and certified nurse aide (CNA) #1 entered the smoking area and approached Resident #1. As they approached the resident, CNA #1 said, Well (Resident #1), I ' ve been looking all over for you! The ADON said, The nurse said he just came out here. CNA #1 assisted the resident to stand and sit on the bench, then escorted him back into the building to his room. When he approached the door into the building, the alarm sounded, triggered by the resident ' s wander guard bracelet. As the resident and CNA #1 approached his room, Resident #1 kept walking down the hall. The CNA had to stop and direct him to his room. Neither the ADON nor any other licensed nurse assessed the resident for injury after he entered his room. At 5:00 p.m., observation of the exit gate from the smoking area, located at the south end of the property, revealed the gate was attached to a chain link fence in a grassy area that joined a paved road. b. Failure to monitor Resident #1 at night as planned A 3/18/2020 IDT risk management progress note revealed Resident #1 was put on 15-minute safety checks and when he was sleeping, staff were to sit in the hall to monitor the door to his room to ensure the resident did not get out of the facility. However, progress notes above dated 4/19 and 4/20/2020 (see above) read Resident #1 had been setting door alarms off by continued door seeking behavior throughout the night (4/19/) and wandering the halls, door seeking through the setting the door alarms off (4/20/). c. Failure to take steps to ensure other unsafe and/or unsanitary behaviors as planned (1) A 2/14/2020 IDT risk management progress note (see above) revealed the resident had a behavior of participating in poor eating etiquette during meal times by reach in other residents ' plates on 2/13/2020. This was first documented in nursing progress notes 11/26/19 and 11/27/19 (see above). However, while the 2/14/2020 IDT note read the resident was to receive meals prior to dining meal times to provide a calmer environment, this intervention was not care planned until 3/2/2020. (2) There was no evidence the facility developed and implemented effective interventions to address Resident #1 ' s urination and defecation in inappropriate locations, which progress notes revealed continued (see above). (3) There was no evidence the facility developed and implemented effective interventions to protect against Resident #1 placing metal objects in electrical outlets. Observations on 4/23/2020 at 12:30 p.m. revealed all electrical outlet sockets in the main dining room were not covered or plugged with any safety mechanisms. D. Record review 4/22/2020, after the facility was informed its failure to meet Resident #1 ' s need for supervision created a likelihood for serious adverse outcome if not corrected. Record review revealed the facility placed Resident #1 on one to one supervision (see abatement plan above) and updated his care plan to read, Resident placed on one to one for safety and care needs. Record review further revealed when receiving this level of supervision, the resident did not attempt to elope. -A 4/23/2020 nursing progress note revealed the resident was on one to one supervision and had no elopement attempts. -A 4/23/2020 a Wandering/Elopement Risk Assessment revealed the resident was a high risk for wandering with a score of 12. -A 4/24/2020 nursing progress note revealed the resident remained on one to one supervision and had no elopement attempts. -A 4/25/2020 nursing progress note revealed the resident continued on one to one supervision, was easily redirect able and had no elopement attempts. Other nursing progress notes on 4/25/2020 revealed the resident exhibited a witnessed [MEDICAL CONDITION] activity in his room at 8:15 a.m. that lasted approximately eight minutes. It indicated the resident hit the right side of his head during the [MEDICAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) CONDITION] and was non-responsive. The resident was sent to the emergency room for further evaluation and treatment and returned to the facility at 3:15 p.m. with no new orders and was able to ambulate back into the facility with a steady gait. -A 4/26/2020 nursing progress note revealed the resident remained on one to one observation with no elopement attempts. -A 4/27/2020 nursing progress note revealed the resident remained on isolation precautions for COVID-19 and had one to one supervision around the clock. E. Staff interviews 1. CNA #1 and agency CNA #2 were interviewed on 4/22/2020 at 4:45 p.m. CNA #1 said she was not Resident #1 ' s CNA; she was unsure of who was assigned to him. CNA #2 said she was not assigned specifically to Resident #1 because all the CNAs were helping each other. 2. Registered nurse (RN) #1 was interviewed on 4/22/2020 at 4:50 p.m. She said about 4:30 p.m., Resident #1 approached the exit door to the smoking area, activating the wander guard alarm. She said she opened the door and allowed him to exit with no staff accompanying him because she had to get back to her cart. She said she thought he was still on every 15 minute checks, since his elopement last month. She was unaware he was sitting on the ground outside in the smoking area. She said he had been care-planned for placing himself o
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on record review and interviews, the facility failed to establish certified nurse aides (CNAs) were able to demonstrate the skills and competencies needed to provide resident care for two out of five CNAs reviewed. Specifically, the facility failed to ensure that all CNAs working in the facility had completed required training and were oriented to the specific needs of the residents in the facility. Cross reference F689: failure to ensure the facility remained as free from accidents hazards as possible. Cross referenced F880: failure to maintain an infection prevention and control program to help prevent the development of transmission of communicable diseases and infections. Findings include: I. Facility policy and procedure The facility ' s undated Staffing Policy Statement was provided via email by the nursing home administrator (NHA) on 5/01/2020 at 11:20 a.m. It read in pertinent part, Our facility provides adequate staffing to meet needed care and services for our resident population. II. Record review Training records for CNA #3, #4, #6, #7 and #8 were provided by the nursing home administrator (NHA) on 4/24/2020 at approximately 11:00 a.m. All five CNAs were permanent facility staff that had worked at the facility for more than one year. The records revealed that CNA #3 and CNA #4 had not completed 12 hours of required annual training. CNA #4 had not received any annual training on abuse or neglect. The records failed to include evidence the facility had a process to establish staff competencies in the performance of basic and specific skills in order to meet the needs of its residents. The facility was unable to provide the training records for agency staffed CNAs who worked in the facility. III. Staff interviews The director of nursing (DON) was interviewed on 4/24/2020 at 2:54 p.m. She said that she tried to touch base with CNAs at least once a week to check in on how they are doing and make sure they were following facility protocols for infection control and providing care appropriately. She said either herself or the assistant director of nursing (ADON) were present on the floor for oversight. She said that the facility utilized an online training system and that staff were responsible to maintain the timely completion of required training. She said that agency CNAs received training from their hiring agency and the facility did not maintain a record of what training they had been provided elsewhere. Agency staffed CNA #5 was interviewed on 4/24/2020 at 12:17 p.m. She said that she had received education on infection control two weeks prior when she was working at a different facility. She said that she had received education from her staffing agency as well. She said that the NHA had given her instructions that morning on what to do if residents were attempting to elope. IV. Facility follow up: The NHA followed up via email on 5/1/2020 at 12:40 p.m. His email read, The staffing agency that we are using educates their staff in accordance to assure that they are able to meet the needs of the residents they provide care to in the communities they serve. In our community, we communicate about our residents and their acuity at shift exchange to assure that agency staff is knowledgeable of our resident needs. The facility did not provide documentation of the agency CNAs ' completion of training or that they had been oriented to the specific needs of the resident population at the facility.
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 observations, record review and interviews, the facility failed to ensure one (#1) resident reviewed for dementia care out of eight sample residents, received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to comprehensively assess and effectively identify person-centered approaches for dementia care for Resident #1 ' s constant exit seeking and other inappropriate behaviors including urinating and defecating in inappropriate areas throughout the facility. I.Resident census and conditions The [DATE]7/2020 resident census and condition form documented 60 total residents with 24 residents (40%) with dementia and 46 residents with behavioral healthcare needs (77%). The facility did not have a secure unit but did have a wander guard system in place. II. Resident #1 A.Resident status Resident #1, age less than 65, admitted [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 2/6/2020 minimum data set (MDS) assessment revealed severe cognitive function with a brief interview for mental status (BIMS) score of two out of 15. The resident had behaviors not directed towards others including physical symptoms such as disrobing in public, urinating and defecating in public and wandering one to three days during the assessment period. The resident was independent with walking in the room and corridor but required minimal assistance of one person for dressing, toilet use and personal hygiene. B. Observations On 4/22/202 at 4:40 p.m. the surveyor exited the door to the smoking area, it was not locked and did not alarm when opened. After entering the outside smoking area, three residents were seen sitting at separate tables smoking. Beyond those residents, and off to the left of a walkway, Resident #1 was seen sitting on the ground, in front of a bench, leaning forward with his forehead resting on a concrete flower pot with his arms at his sides. There was no staff member with him. His left leg was bent underneath him and his right leg was bent at the knee and extended out to his right. He was wearing a long sleeved shirt, pants, had one sock on his left foot, and his right foot was bare. His speech was incoherent and he was unable to say why he was sitting on the ground or whether he was injured. At 4:41 p.m. the assistant director of nursing (ADON) and certified nurse aide (CNA) #1 noticed the surveyor outside standing in front of Resident #1. As they approached him, CNA #1 said, Well (Resident #1), I ' ve been looking all over for you! The ADON said, The nurse said he just came out here. CNA #1 assisted the resident to stand and sit on the bench, then escorted him back into the building to his room. When he approached the door into the building, the alarm sounded, triggered by the wander guard bracelet. As the resident and CNA #1 approached his room he was unaware of where his room was and kept walking down the hall. CNA # had to stop him and direct him into the correct room. C. Record review The behavior care plan, initiated 12/28/2018 and last revised 4/22/2020, revealed the resident had the potential to display unprovoked verbally and physically aggressive behavior toward others. He displayed episodes of smearing feces and defecating and urinating in inappropriate places. Interventions included placement of a wander guard and to seek alternative placement with memory care focus, decreased stimulation and a secure unit. The care plan did not address the residents wandering and exit seeking behaviors except for the use of a wander guard. The care plan did not address the resident ' s behavior of urinating and defecating in inappropriate places. The April 2020 CPO included: -Check placement and function of wander guard every shift, initiated 3/17/[DATE] and -Monitor for exit seeking behaviors, initiated 2/17/2020. The resident ' s record was reviewed on 4/21/2020 at 1:35 p.m. Nursing and behavior progress notes from August 2019 until present revealed the resident had increasing to constant exit seeking behaviors with frequent episodes of urinating and defecating in inappropriate areas throughout the facility and was difficult to redirect. (Cross reference F689) Review of the nursing progress notes revealed: -On 8/2/19 the resident was found walking down the street by staff. -During the month of November 2019 the resident had exit seeking behaviors five days and defecated in the sink once. -During the month of December 2019 the resident had exit seeking behaviors eight days and urinated and defecated in inappropriate areas twice. -During the month of January 2020 the resident had exit seeking behaviors 11 days and urinated and defecated in inappropriate areas five times. -During the month of February 2020 the resident had exit seeking behaviors four days and urinated and defecated in inappropriate areas once. -During the month of March 2020 the resident had exit seeking behaviors 11 days and urinated and defecated in inappropriate areas twice. -During

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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 4) the month of April 2020 the resident had exit seeking behaviors 11 days between [DATE]/2020 and 4/22/2020 at which point the resident was put on one to one supervision with a staff member and no longer had documented exit seeking attempts. Further review of the resident ' s record on 4/21/2020 at 1:35 p.m. revealed the facility did not implement any interventions or update the care plan except for the following: -On 11/27/2019 the care plan was updated to include: keep the resident in line of sight while out of room related to history of aggression towards other residents and seek alternative placement with memory care focus, decreased stimulation and a secure unit. -On 2/13/2020 the care plan was updated to include: Keep in line of sight while out of room related to history of aggression toward other residents. -On 2/14/2020 the care plan was updated to include: Provide the resident with materials for individual activities as desired. He liked the following independent activities - reading, drawing, pet visits, and intergenerational visits -On 3/14/2020 the resident was placed on safety checks and was to be kept in the facility or monitored outside with staff at all times. The care plan was updated on 3/14/2020 to include: the resident will not be outside in the fenced courtyard unsupervised. -On 3/18/2020 IDT risk management progress note revealed the resident was put on 15 minutes safety checks and when he was sleeping staff were to sit in the hall to monitor the door to his room to ensure the resident did not get out of the facility. It indicated the resident was redirected when he tried to go outside or staff went outside with the resident. The care plan was not updated with this intervention and the 15 minute checks did not continue. -On 4/22/2020 the care plan was updated to include: Resident placed on one to one for safety and care needs. Review of the record revealed after the resident was placed on one to one supervision, he no longer had exit seeking behaviors. Review of the behavior tracking on 4/30/2020 for February 2020 to April 2020 revealed the resident was to be monitored for exit seeking behaviors every shift for safety however the records were blank with no behaviors being documented. D. Staff interviews CNA #9 was interviewed on [DATE]7/2020 at 4:25 a.m. She said there were two nurses and two CNAs on duty for the night shift. She said if a resident was wandering they had to rely on the door alarms to let them know if a resident was attempting to elope and they provided redirection to the residents. Registered nurse (RN) #1 was interviewed on 4/22/2020 at 4:50 p.m. She said she thought the resident was still on 15 minute checks since his elopement last month. She said the resident was difficult to redirect at times. The director of nursing (DON) was interviewed on 4/22/2020 at 5:10 p.m. She said the resident was no longer on every 15 minute checks. She said he still had the wander guard bracelet and was to be in line of sight of a staff member when he was out of his room. The nursing home administrator (NHA) was interviewed on 4/22/2020 at 5:15 p.m. He said he felt the interventions they had put in place for Resident #1, since his elopement, that included continued use of the wander guard bracelet, the initial 15 minute checks and for him to be in line of sight of the staff when he was out of his room, was sufficient as he hasn ' t done it again and has not gotten hurt. He said, The resident had a right to go outside even if he had the wander guard bracelet on. The clinical nurse consultant (CNC) was interviewed on 4/22/2020 at 8:55 p.m. He said the facility needed to assess the resident further to determine the reason the resident was constantly exit seeking and implement interventions to decrease this behavior. He said interventions should have also been put into place for the resident behavior of urinating and defecating throughout the facility. CNA #3 was interviewed on 4/24/2020 at 10:55 a.m. She said she received yearly training on elopement and wandering. She said they would eyeball those folks that might do that. She said if a door alarm went off, then she would go to that door to see if a resident was trying to get out and redirect them. CNA #6 was interviewed on 4/24/2020 at 11:29 a.m. She said she had received training for elopement the previous day and had been told if a door alarm was going off, she was to notify the charge nurse and wait for instructions. The DON was interviewed again on 5/5/2020 at 4:37 p.m. She said the facility had a staff member providing one to one supervision for Resident #1 around the clock. She said since he was recently diagnosed with [REDACTED]. She said when he tried to come out of his room, the staff would redirect him. If he continued to want to come out of his room, the staff would walk with him. She said they also had an activity cart outside his room and found that music and the sound of running water relaxes him.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observations, record review and interviews, the facility failed to maintain an effective infection control program. Specifically, the facility failed to: -Effectively screen visitors for COVID-19 upon entering the facility; -Properly wear N-95 masks; and -Ensure dedicated staff only cared for isolation residents. Findings include: I.Professional reference According to the Centers for Disease Control and Prevention (CDC) updated [DATE]5/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: -Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility; -Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19; -Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap); and -Assign dedicated healthcare providers (HCP) to care for residents with confirmed COVID-19. II. Screening of visitors On [DATE]7/2020 at 4:00 a.m. two surveyors entered the building and were not screened by certified nurse aide (CNA) #9 or registered nurse (RN) #2 for COVID-19. Their temperatures were not taken and they were not asked about any symptoms or recent travel. They were escorted behind double doors to the unit and were informed at that time that they had positive COVID-19 residents in the facility. At 4:45 a.m. COVID-19 employee screening sheets were seen on the table by the front door in the lobby. They did not have a screener name on them and their temperature was not recorded. At 5:10 a.m. a housekeeper was cleaning the bathroom in the front lobby. She said she had come in the back door and gone to the nurses station to be screened for COVID-19 prior to working. On 4/22/2020 at 8:00 p.m. two state surveyors entered the building and had to request to be screened by the RN to enter. The RN could not find the thermometer and had to request another staff member to get one. Temperatures were taken orally. The screening forms filled out were for employees and were not reviewed by the RN prior to allowing the surveyors to enter the facility. The surveyors recorded their own temperatures on the forms. On [DATE]20 at 9:00 a.m. upon entering the facility, the thermometer used to screen visitors read four different readings from 99.2-100.2 degrees Fahrenheit (F) for one person in a two minute time frame. A different thermometer was obtained so accurate temperature could be taken. The screening form was for visitors and was reviewed by staff before allowing entry. On 4/24/ at 9:00 a.m. upon entering the facility a new thermometer was being used to screen staff and visitors. III. PPE use At 3:00 p.m., the nursing home administrator (NHA), the director of nursing (DON), the clinical nurse consultant (CNC), and the regional director of operations (RDO) entered the conference room for interviews. They were wearing N95 masks with the bottom elastic strap dangling below their chins, causing a gap between the mask and their face. They were unaware of the appropriate application of the mask to ensure maximum protection. When they were made aware of the ineffective use of the mask, they applied them correctly. IV. Interviews RN #2 was interviewed on [DATE]7/2020 at 4:10 a.m. She said there were two nurses and two CNAs working the night shift. She said the nurses divided up the residents in isolation to make it easier. CNA #9 was interviewed on [DATE]7/2020 at 4:25 a.m. She said there were two nurses and two CNAs on duty for the night shift. She said they were not assigned specific residents but provided care for all of them including the resident ' s in isolation. The DON was interviewed on 4/24/2020 at 12:45 p.m. She said after the facility had two positive cases of COVID-19 they no longer were testing any residents. She said they were isolating any residents that were symptomatic along with their roommates. She said the residents in isolation were being cared for by both nurses and those nurses were also caring for other residents. She said they were wearing N-95 masks and covered them with a surgical mask. The director of clinical operations (DCO) was interviewed on 4/24/2020 at 2:30 p.m. She said the N-95 masks should only be worn by staff going into isolation rooms. She said staff assigned to the isolation rooms should not be caring for residents in non-isolation rooms.