STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, interviews, and record review, the facility failed to ensure three residents (#1, #2 and #3) of three residents out of 13 residents at moderate/high risk for elopement, received adequate supervision and assistive devices to prevent accidents. The facility failed to provide Residents #1, #2 and #3 the supervision necessary to prevent elopements. These facility failures created a situation with serious harm and the likelihood of serious harm to residents' health and safety if not immediately corrected. Resident #1, diagnosed with schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions) and mood disorder, eloped from the facility on 4/2/23 at 2:00 p.m. when he signed out. It was discovered the facility was not monitoring the sign-out book and it was not perceived that the resident was missing from the facility until 4/3/23 at 9:00 a.m. (over 18 hours later). Resident #1's whereabouts were unknown until 4/4/23 at 11:00 a.m. (over 45 hours later) when the facility was informed that he was at a distant hospital. According to 4/2/23 hospital records, Resident #1 was admitted to the hospital on 4/2/23 on a M1 (emergency mental health hold) hold due to suicidal ideation. The resident had tried to jump in front of traffic during the elopement and attempted suicide, which was unsuccessful. The facility responded by educating nursing staff about missing person protocol. The education proved to be ineffective as additional resident elopements occurred 13 and 16 days later. Staff were unaware of these elopements until notified by community members. Resident #2, diagnosed with paranoid schizophrenia, dementia with behavioral disturbance and cognitive communication deficit, eloped on 4/18/23 out the front door and was not discovered to be missing until the facility received a call from a convenience store at 1:45 a.m. The facility door was alarmed at night but either it did not alert or the staff did not respond to Resident #2's exit. Resident #2, assessed by the facility to be cognitively intact, reported leaving the facility at 12:20 a.m. An employee from the convenience store reported that Resident #2 attempted to get into a stranger's car. Resident #2 said she intended to walk or get a ride to the city of [NAME] (about 36 minutes away from the facility) and was resistant to return to the facility when the facility staff came to retrieve her. According to the 4/18/23 facility's investigation, staff said they noticed she was gone at 1:45 a.m (at the same time they were notified by the convenience store). Record review revealed the last staff interaction with Resident #2 was at 9:45 p.m. after staff conducted a pain assessment (it was four hours before the facility noticed the resident was gone). (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility responded by conducting an updated wandering assessment, completed upon Resident #2's return and revealed the resident was at high risk for wandering and the use of a wander prevention device was recommended. However, there was no evidence this recommendation was implemented and a wander prevention device was currently not in use for Resident #2. The care plan was not updated with interventions related to elopement. Resident #3, diagnosed with unspecified dementia and cognitive communication deficit, had eloped on 4/21/23 at approximately 9:00 a.m. He had eloped from the back patio gate which was unlocked. Resident #3 was found by a neighbor from the apartments next door, he was lying on the ground by the fence outside of his apartment. Resident #3 had a fall that resulted in skin tears to the left side of torso, left inner wrist and small scratches under his chin. Resident #3 denied hitting his head but was unable to recall how he fell . Resident #3 had packed a bag and said he intended to leave the facility with no intention to return. The facility responded by placing a wander prevention device on Resident #3. The facility's failure to implement an immediate and comprehensive review of the facility's system and response to Resident #1's elopement on 4/2/23, as well as Residents #2 and #3 elopements, placed residents at risk for serious harm if immediate corrections were not implemented. Findings include: I. Immediate Jeopardy A. Findings of immediate jeopardy Review of the elopement investigation from 4/2/23 for Resident #1, observations conducted from 5/1/23 through 5/2/23 and staff interviews revealed the facility failed to provide Resident #1, #2, and #3 with a safe environment and adequate supervision to avoid preventable accidents. Specifically, the facility failed to take immediate and comprehensive steps following Resident #1's elopement on 4/2/23, to review, revise and sufficiently educate staff, evaluating the effectiveness of the education, on how to protect Resident #1, as well as Residents #2 and #3. There was no evidence the facility thoroughly investigated the incident to uncover and address why the staff did not appropriately report a missing person for Resident #1, why no alarm was heard or responded to for Resident #2 at the front door and why the back door was unsecured where Resident #3 eloped. B. Facility notice of immediate jeopardy On 5/2/23 at 2:00 p.m. the nursing home administrator (NHA) was notified that the facility's failure to provide residents with a safe environment and adequate supervision to avoid preventable accidents created an immediate jeopardy situation. C. Facility plan to remove immediate jeopardy On 5/3/23 at 3:45 p.m. the facility submitted a final plan for the immediate jeopardy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The plan read: On 5/2/23 at 3:00 pm the following actions were taken: -Resident #1 has been discharged . -Director of nursing/designee completed updated wander risk assessment on Resident #2 and Resident #3. IDT(interdisciplinary team) reviewed and interventions initiated and care plan updated related to elopement risk. -Director of nursing/designee provided immediate training/education to staff responsible for monitoring the front door and responding to alarms at the door. -Administrator/designee validated gate on patio, which is not considered an exit, was securely locked to prevent exit via this route. -Administrator/designee validated all doors are functioning as appropriate, locking appropriately and alarming as expected with exits. -Administrator/designee initiated staff monitoring of the front exit door at all hours on 5/2/23 to assure the door was under constant monitoring as an ongoing intervention. IDENTIFICATION OF OTHERS AFFECTED: All residents have the potential to be affected. -Director of nursing/designee completed assessment of all residents wander risk in point click care (facility electronic medical record) on 5/2/23. -Director of nursing/designee validated all residents at high risk of elopement/show signs of wandering, have appropriate interventions and plan of care in place per risk assessment on 5/2/23. -Director of nursing/designee has been validated that all residents with order/intervention for wander guard, have one in place and functioning as started on 5/2/23. -Director of nursing/designee will complete wandering assessments within 72 hours on every admission ongoing starting on 5/3/23. SYSTEMIC CHANGES AND/OR MEASURES: -The corporate RN (registered nurse) consultant provided training and material to the director of nursing and administrator of wandering/unsafe resident and elopement risk policy started on 5/2/23. -The corporate RN consultant educated administrator on requirement to validate doors are functioning properly and facility doors/gates are secured as per facility plan. Reception to validate that the front door are functioning properly. Maintenance to validate all other doors in the building are working properly. Completed on 5/2/23. -The director of nursing/designee completed education with all staff on missing resident protocol and proper response to alarms in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All education and training were started on 5/2/23 and will continue until all staff have received training prior to the start of their work shift. -Administrator/designee initiated inquiries on 5/2/23 for a camera system to assist in remote monitoring of doors for potential elopement risks. -Administrator/designee will provide education to the receptionist/door monitor on the process of checking the sign out log to validate that resident has logged an anticipated return time and the expectation that frequent monitoring to validate that the resident has returned as indicated on log. Education will be initiated on 5/2/23 and ongoing will all new staff attending to doors prior to shift. -Ad hoc QAPI (quality assurance and performance improvement) meeting held with the IDT team and MD (medical doctor) to review policy on missing persons, elopement risks and plan of removal/response to immediate jeopardy citation on 5/2/23 at 3:45 p.m. Tracking and Monitoring -Director of nursing/designee will review residents with high wander risk identified by doing wandering assessments upon admission for every resident, to assure appropriate interventions and plan of care are in place daily for seven days beginning 5/3/23, then five times per week. -Administrator/designee will monitor exits for appropriate functioning and alarms as installed five times per week beginning 5/3/23. -Administrator/designee will complete audit of resident sign out log daily for seven days, then five times a week to assure residents are completing anticipated time of return and receptionist is monitoring return each day, beginning 5/3/23. -Director of nursing/designee will monitor new orders for wander guard, and validate that placement of the wander guard device has occurred and appropriate care planning for device has been implemented five times per week, beginning 5/3/23. -Administrator/designee will complete a random audit every shift for seven days, beginning 5/3/23, for appropriate staff response to alarms, immediate education will be provided if necessary, then will monitor random shifts, five times a week. -Administrator/designee will monitor all residents on pass to ensure timely return and proper notification will be provided to administrator/director of nursing if resident does not return upon expected time. If a resident does not return at expected return time, administrator/ director of nursing will contact family and follow elopement policy. If a family is contacted and the resident is running late, the provider will be notified and order will be added for pass extended. D. Removal of immediate jeopardy The above plan was accepted and based on the facility plans above, the immediate jeopardy was removed on 5/3/23 at 3:45 p.m. However, deficient practice remained at an G scope and severity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	II. The facility failed to identify risk for elopement and ensure the safety of three residents (#1, #2 and #3). A. Facility policy and procedure The Wandering, Unsafe Resident policy and procedure, revised 2022, was provided by the director of nursing (DON) on 5/3/23 at 11:33 a.m. It read in pertinent part, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. A missing resident is considered a facility-wide emergency. If a resident is missing, the elopement/missing resident emergency procedure will be initiated: determine if the resident is out on an authorized leave or pass; if the resident was not authorized to to leave, initiate a search of the building(s) and premises; if the resident is not located, notify the administrator and the DON services, the resident's legal representative (sponsor), the attending physician, law enforcement officials, and (as necessary) volunteer agencies (emergency management, rescue squads); provide search teams with resident identification information; and initiate an extensive search of the surrounding area. When the resident returns to the facility, the DON shall complete and file an incident report; and document relevant information in the resident's medical record. B. Resident #1 1. Resident status Resident #1, age under 65, was admitted initially on 3/22/23, readmitted [DATE] from acute care hospital and discharged [DATE] due to elopement. According to the April 2023 computerized physician orders (CPO), diagnoses included hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease (kidneys have stopped doing their job to filter waste from your blood causing high blood pressure and heart disease), type 2 diabetes mellitus and schizoaffective disorder. He attended dialysis three days per week. The incomplete 3/22/23 entry, 3/26/23 discharge return anticipated, 3/27/23 entry and 4/2/23 discharge return not anticipated minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required limited assistance with transfers and showers; supervision with bed mobility, walking in room/corridor, dressing, eating, toilet use, and personal hygiene. The activities of daily living (ADL) support provided were not recorded. The MDS revealed no behaviors, no rejection of care and no wandering behavior exhibited. He received seven days of antipsychotic medication, six days of antidepressant medication, one day of antibiotic and seven days of diuretic medication. 2. Review of 4/2/23 incident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/1/23 at 2:30 p.m. the DON provided the investigation of the resident's elopement on 4/2/23. The final report revealed the following: Resident #1 signed out to go out on pass at approximately 2:00 p.m. and did not return. Stated to the nurse that he was going to the convenience store across the street. Consumer location at the time of elopement-unsecured unit, with general population oversight. The resident was last observed by staff on 4/2/23 at 2:00 p.m. The occurrence was not witnessed. Risk level at the time of elopement was at risk to self, with risk factors of mental health and homelessness. Investigation started 4/3/23 with staff interviews and checking the cameras. Other residents were kept safe during the investigation by calling the police and the resident's brother to ask about his whereabouts. A grounds search was conducted and the residents whereabouts were unknown. The resident was missing for approximately 40 hours. The resident was not assessed because he did not return to the facility. The resident was transferred to a higher level of care and ended up at the hospital. The resident did not return to the previous level of care because the resident was still in the hospital. Results of documentation review and interviews revealed the resident signed out to go on pass on 4/2/23 and did not return. On 4/4/23 the facility was informed that he was at the hospital. Policy and procedures were not followed. The DON/NHA (nursing home administrator) were not informed about the resident signing out and not returning. Conclusion was the facility determined that this met elements for a missing person due to the resident signing out but did not return and his whereabouts were unknown. No changes were made to the residents treatment regimen and/or care plan as a result of the occurrence because the resident did not return to the facility. Interventions that were put into place to help prevent a recurrence included education to certified nurse aides (CNAs) and nursing about missing person protocol. Police, family/guardian, ombudsman, and physician were notified. Elopement incident report: dated 4/3/23 at 8:50 am. DON was notified of the resident missing by the assistant director of nursing (ADON). DON investigated the incident and interviewed staff. Resident had signed himself out at 2:00 p.m. on 4/2/23 and he did not return to the facility. Resident #1 had no behaviors and did not verbalize wanting to leave the facility prior to signing out of the facility for pass. DON spoke to Resident #1's representative regarding the resident and the family member had not heard from him. The physician and police were notified. Reportable was completed. Admissions/DON received a call from the hospital on 4/4/23 around 11:00 a.m. to notify us that the resident was at their facility. Unable to get Resident #1's description of the incident or perform a head to toe skin check due to the resident not returning to the facility. Police notification was 4/3/23 at 9:00 a.m., physician 4/3/23 at 9:10 a.m., family member on 4/3/23 at 9:00 a.m. Statement by the DON, dated 4/3/23, Resident signed out in book on 4/2 at 1400 (2:00 p.m.) and has not returned to the facility. Spoke to the resident's brother and he has not heard from the resident. Resident was reported missing to police and reportable was completed. MD (medical doctor) notified. AMA(against medical advice) paperwork completed as discharge was not safe. Will continue to monitor changes. Interviews conducted by DON: Interviewee: Licensed practical nurse (LPN) #1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When was the last time that you saw the resident? I saw the resident right before 2 p.m. and he said he was headed across the street to (convenience store). Did you see him prior to your shift ending? No, I gave a report to the nurse that he had signed himself out on a pass. Did you report him missing? No he was out on pass and usually gone for a bit. Interviewee: CNA #2 When was the last time that you saw the resident? I did not see him during my shift. Did you see him prior to your shift ending? No, I was not taking care of him at that time. Did you report him missing? No. Interviewee: CNA #3 When was the last time you saw the resident? I saw the resident briefly around 6 pm. Did you see him prior to your shift changing? The last time I saw him was around 6 pm. Did you report him missing? No. -The conclusion of the report indicated it was substantiated that the resident left the facility unattended and was later located by a hospital. 3. Record review- steps taken after the resident's elopement on 4/2/23 Progress notes The 4/2/23 at 5:38 a.m. nurses note revealed, Resident remains on antibiotic ointment to right eye with no adverse effects noted tonight. He is complaining of not being able to sleep with the trazodone 100mg he is on now. Will call MD on Monday morning to request an increase in his Trazodone order. Vital signs are within normal limits this shift. The 4/3/23 at 8:56 a.m. nurses note revealed, Nurse was told in report that resident left yesterday day shift and has not returned since. Nurse reported it to the ADON. The 4/3/23 at 9:58 a.m. nurses note, late entry revealed, Resident signed out in book on 4/2 at 1400 (2:00 p. m.) and has not returned to facility. Spoke to the resident's brother and he has not heard from the resident. Resident was reported missing to police and reportable was completed. MD notified. AMA (against medical advice) paperwork completed as discharge was not safe. Will continue to monitor for changes. The evening 4/2/23 and morning 4/3/23 medication administration record (MAR) was marked as out of facility. -The facility staff recognized that Resident #1 was gone but did not act and his whereabouts were unknown. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The in-service attendance form, provided by the DON on 5/1/23 at 4:10 p.m , read in pertinent part, In-service title: Frequent checks. Topics discussed: Resident's must be checked on frequently. If a resident appears missing, the administrator or DON must be notified immediately. Staff must immediately search the premises for the resident and the nurse must complete a risk management. Instructor's name: DON. Required departments: nursing. Date of in-service: 4/3/23, mandatory in-service. Signed by 28 staff members. Hospital medical records for Resident #1 were received from the hospital on 5/1/23 at 2:20 p.m. The hospital records revealed Resident #1 was admitted on [DATE] and discharged on [DATE]. The emergency department (ED) records, dated 4/2/23 revealed in pertinent part, (age)year old male with a history of schizoaffective disorder, depression here with suicidal ideations. Patient states he is living in a nursing home in Lakewood, he got on a bus trying to get back to California. He was feeling suicidal today and felt that he needed to jump in front of traffic. It is unclear though it seems the patient eloped from his nursing home down in Denver. States that he attempted to do this earlier however he was brought here instead. Medical decision making: Assessment: He is complaining of suicidal ideations and concern for possibly running into traffic. It is of note that he may have eloped from his nursing home in Lakewood, Colorado. ED course/reevaluation: Patient admitted /observed overnight pending social work evaluation. The Psychiatry consult, dated 4/3/23 at 9:30 a.m. revealed in pertinent part, Patient is a (age) year old male with a history of schizophrenia, depression, anxiety, hypertension, CKD (chronic kidney disease) analysis presented to the ER (emergency room) reporting suicidal ideation. Patient stated that he was living in a nursing home in Denver for awhile and he reportedly left because he was feeling suicidal. The patient reports trying to go to Grand Junction however he missed his bus at Vail and started feeling suicidal. Patient said he tried to jump in front of the traffic which reportedly did not work out. Patient said he had been out of his medications for more than a month and had anxiety and depression symptoms. Today he continued depression symptoms, feelings of hopelessness and worthlessness. He reported stress due to his underlying medical issues and expressed hopelessness. Past Psychiatric history: Inpatient treatment: last hospitalization was over three years ago. Suicide attempts: Previous history of two suicide attempts. Mental status exam: mood: depressed. Affect: Flat. Thought content: Suicidal ideation. Insight: Limited. Judgment: Impaired. Assessment: Patient reports feeling depressed in the context of his medical issues and physical disability. He continued to endorse hopelessness and does not contract for safety. Patient is judged to be at imminent risk and meets criteria for acute inpatient psychiatric hospitalization . DSM 5 (standard classification of mental disorders) diagnoses: Major depressive disorder; recurrent and moderate schizophrenia. Plan: Restart Risperdal (antipsychotic medication) for schizophrenia; start Zoloft (depression medication) for anxiety and depression; continue trazodone (depression medication); transfer to acute inpatient psychiatric unit once medically cleared; recommend involuntary psychiatric placement due to safety concerns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Staff interviews Registered nurse (RN) #1 was interviewed on 5/2/23 at 4:20 p.m. She said residents should be checked by nurses every two hours. RN #1 said if a resident misses medication administration the nurse staff did a search, checked the book if signed out and searched for the resident especially if they were an elopement risk. RN #1 said if the resident was still missing, the nurse would call the family, doctor, the DON and the NHA. CNA #4 was interviewed on 5/2/23 at 4:21 p.m. She said she tried to check on residents every two hours but sometimes it was hard with so many residents to care for. CNA #4 said her residents tell her if they were going to go out on a pass. CNA #4 said if they were gone for more than 45 minutes she knew something was wrong because usually the residents were not gone very long. CNA #4 said if the resident was gone for an hour she would report that to her nurse and it would go up through the chain of command (up to administration). The DON was interviewed on 5/3/23 at 11:00 a.m. She said she thought the wandering assessment screenings were being done for everyone on admission and were in the resident admission packets. She said the wandering assessments were not being done, she would now implement them from now forward. The DON said with Resident #1's elopement, the nurse staff were aware he was missing but did not act because it was a communication error. The DON said the CNAs should be checking on the residents every two hours for any needs. The DON was interviewed again on 5/3/23 at 12:15 p.m. She said she was not sure if there was a system for regular checks on residents but would encourage it. The DON said she would usually provide education to the residents on the front desk sign in/sign out process at admission. The DON said it was important to emphasize to the residents to know when they were going out and when they would be returning. The DON said she would now educate the residents to notify the facility if they would be late and to call the receptionist who checked the sign in/sign out book. The DON acknowledged that prior to the survey no staff had been assigned to check the sign in/sign out book. The DON said if a CNA noticed that a resident missed a meal, the CNA should see if they had a pass to go out, look for the resident and contact the family. The DON said triggers for the staff to look for a resident were if the resident had not been seen in the past two hours, missed a meal or missed medication administration. The DON acknowledged that prior to the survey there was no staff at the front desk at night. The DON said every resident now had a wandering assessment. The DON said for Resident #1, the nurses on duty failed to communicate with the administration that the resident was missing and those nurses had corrective action and additional education. The DON said the preferred process was for the CNA to tell the nurse and to search for the resident. The nurse would check if the resident signed out on pass, and to notify the DON and the NHA. The DON said the receptionist would now check the sign-in book to make sure the residents arrived. The DON said the facility's policy and procedures were not followed with Resident #1 because the nursing staff did not inform her or the NHA about the resident not returning. The DON said the 4/3/23 staff education plan had documented to frequently check on residents but it was not specific enough so she would be re-visiting the education. The DON said the education to staff was not effective due to other residents eloping after Resident #1. The DON said it was important for the staff to follow the missing person protocol so the facility could locate the resident and make sure they were free from injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The front desk receptionist (REC) #2 was interviewed on 5/3/23 at 5:50 p.m. He said his shift was from 5:30 p.m. to 4:00 a.m. He said he received education on the new resident sign in/sign out procedure from the NHA. He said he received his education over the phone yesterday (5/2/23) and in person today. He said the resident sign in/sign out book was now located at the receptionist desk where the book and residents could be seen when leaving. He said if the resident did not return at the designated time he was to tell the nurse on the unit where the resident lived and to call the DON. The NHA was interviewed on 5/3/23 at 4:55 p.m. He said the facility would develop a sign in/sign out policy if they did not have one. The NHA said they had just completed resident education on the new facility sign in/sign out process. C. Resident #2 1. Resident status Resident #2, age 77, was admitted on [DATE]. According to the May 2023 CPO, diagnoses included paranoid schizophrenia, dementia with behavioral disturbance and cognitive communication deficit. The 4/22/23 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. It indicated the resident had delusions but no wandering behavior. The resident was independent for locomotion on and off the unit and independent for bed mobility, dressing, toileting and personal hygiene. 2. Wandering assessments The 12/13/22 wandering assessment showed Resident #2 had a moderate risk of wandering and was a known wanderer and had a history of wandering. The 3/13/23 wandering assessment showed she was a low risk of wandering and did not indicate she was a wanderer or had a history of wandering. On 5/2/23 at 3:43 p.m. the director of nursing (DON) provided a treatment record of Resident #2 last known documented observation before she was reported missing on 4/18/23 at 1:45 a.m. The documentation revealed a pain evaluation was completed for the resident by LPN # 3 on 4/17/23 at 9:45 p.m. 3. Review of 4/18/23 incident The 4/18/23 investigation included the final report, an interview of the resident and interventions completed. -The investigation did not include witness statements. The final report revealed the following: -At approximately 1:45 am on 4/18/23 the nurse on shift noticed Resident #2 was not in the facility. The facility received a phone call from the convenience store across the street at approximately 1:45 a.m., stating Resident #2 was there. The resident was then returned back to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The report documented the level of oversight which was provided at the time of the incident was identified as general population (a resident not in the secured unit). The report indicated the facility was not aware the resident had left the facility unaccompanied until they were notified by the convenience store at 1:45 a.m. on 4/18/23. It revealed the last time the resident was observed was at 1:00 a.m.; the resident was missing for 45 minutes. -The facility actions revealed the resident left the facility because she had been experiencing delusions. The facility report revealed Resident #2 received her psychotropic meditation injection on 4/16/23 two days late on 4/18/23 due to it not arriving from the pharmacy timely. The facility interventions included ensuring the resident's psychotropic medication was ordered a week before it was to be administered. -The conclusion of the internal investigation determined the incident met the criteria of a missing person. 4. Resident observation and interview On 5/2/23 at 9:43 a.m. Resident #2 was observed leaving her room with her walker and walking down the corridor to the main dining area. The resident was observed moving around the facility independently. Resident #2 was interviewed on 5/2/23 at 10:50 a.m. The resident said she left the faciity on [DATE] at 12:20 a.m. Resident #2 said she wanted to go home to [NAME], CO and decided she would walk there. Resident #2 said she left by the front and did not see any staff members in the halls on her way out nor did she hear an alarm. She said she decided she should try to get a ride to [NAME] from the convenience store across the street. She said she offered a hundred dollars to a man who agreed to give her a ride. Resident #2 said she did not get into the car because the nursing staff arrived before the man returned to his car from the store. 5. Record review-steps taken after the resident's elopement on 4/18/23 A wandering assessment was completed on 4/18/23 following the elopement incident. It indicated she was a high risk of wandering, was a known wanderer and had a history of wandering. It revealed that a wander/elopement alarm was indicated. Resident #2 had a wandering care plan that was initiated on 4/18/23 which revealed the resident was at risk for injury due to moderate risk of wandering. -The goals initiated on 3/ [TRUNCATED]