STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. BUILDING _____ B. WING _____	04/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PUEBLO CENTER	2611 JONES AVE PUEBLO, CO 81004

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	**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 observations, record review and interviews, the facility failed to provide and document sufficient medically-related social services to one (#3) of three residents reviewed. Findings include: I. Facility policy Discharge against medical advice (AMA) policy, revised 1/31/2020, provided by the nursing home administrator (NHA) on 4/20/20 at 1:50 p.m. Policy: .A discharge Transition Plan will be provided to the patient or resident representative . Appropriate discharge documentation will be completed as applicable. Process: 1.1.3 Immediately notify the Physician/Advance Practice Provider (APP) and the resident representative that the patient wishes to discharge himself/herself. 1.1.4 Immediately notify the Center Executive Director (CED), Center Nurse Executive (CNE), and Director of Social Services of an AMA discharge request. 2. The CED or designees will notify the Medical Director. 7. The Discharge Transition Plan will be provided to the patient or resident representative. Efforts will be made to make referrals to community resources and agencies to the extent time permits. 8. Documentation will be made in the medical record with details of the discharge to include: 8.1 Persons and agencies notified, 8.2 Statement of reason for discharge (if known), 8.3 Explanation of benefits of remaining in the Center, 8.4 Explanation of potential complications, risks, and consequences of leaving the Center against the advice of the physician, 8.5 Date and time of discharge, mode of transportation, and by whom. II. Resident #3 A. Resident status Resident #3, age 63, was admitted on [DATE] and readmitted on [DATE] and discharged AMA on 4/8/2020. According to the April 2020 computerized physician orders [REDACTED]. The [DATE]/2020 minimum data set (MDS) assessment revealed the resident's cognitive status was intact with a brief interview of mental status (BIMS) of 15 out of 15. She had verbal behavior symptoms directed to others occurring 1 to 3 days from the past seven, and did not reject care during the assessment period. B. Record review The care plan, initiated 1/2/2020 and revised on 1/14/2020, identified the potential for discharge related to the resident was at the facility for a 30 day respite and was expected to return home upon completion of respite. Interventions included to identify and document resident/patient desires and concerns/barriers regarding discharge, discuss with resident/patient and HCDM/family members any potential barriers to discharge transition planning, and encourage resident/family to participate in plan of care. The care plan, initiated on [DATE]20, identified psychosocial distress related to limited visitation secondary to infection prevention practices. Interventions included: -Assist resident/patient in accessing telephone, electronic, alternative means of communication with family/friends/resident representative(s), -Provide emotional support as needed based on resident's/patient's response, -Provide person-centered, individualized diversional opportunities. The care plan, initiated 1/2/2020, identified clinical management for [MEDICAL CONDITION]. Interventions included [MED]gen by (via) nasal cannula (NC) per medical doctor (MD) order. The care plan, initiated 1/3/2020, identified risk for respiratory complications related to asthma, [MEDICAL CONDITION], seasonal allergies [REDACTED]. Interventions included [MED]gen (O2) as ordered via (undocumented amount) mask/nasal cannula. The care plan, initiated 1/2/2020 and revised [DATE]/2020, identified risk for [MEDICAL CONDITION] activity related to history of [MEDICAL CONDITION] disorder. Interventions included, medicate as ordered and monitor for effectiveness as well as side effects and report to physician as needed. The care plan, initiated [DATE]20, identified the resident reported past experience of trauma as evidenced by sexual abuse as a child and reports to be verbally and physically abused as a child. Interventions included: -Be sensitive to privacy and confidentiality. -Offer sufficient notice and prepare patient when changes are necessary. -Maintain communication that is consistent, open, respectful, and [MEDICATION NAME]. -Respect concerns and questions. -Listen to resident/patient and treat without judgement or guilt. The April 2020 Medication Administration Record [REDACTED]. Start date of [DATE]. -Levetiracetam tablet 500 milligrams. Give 500 milligrams by mouth two times a day for [MEDICAL CONDITION] disorder. Start date [DATE]. -Montelukast sodium tablet. Give 10 milligrams by mouth at bedtime for [MEDICAL CONDITION]. Start date [DATE]. -[MEDICATION NAME] tablet extended release 12 hour. Give 600 milligrams by mouth two times a day related to [MEDICAL CONDITION]. Start date [DATE]. The resident council meeting minutes dated 3/13/2020 at 2:00 p.m. included: 1. Pueblo has been notified that there is one confirmed case of coronavirus. 2. We are asking that no resident leave the facility unless it is a medical emergency. 3. There will be no visitors or vendors allowed in the facility until restriction is uplifted. The resident update for COVID-19 dated 4/2/2020 included: 6. A reminder to stay in your room as much as possible. You must stay within six feet from others. Please maintain your social distancing. 7. Activities has been taking folks outside for daily walks. Please get with them if you would like to go. The meeting minutes did not include education that if a resident chose to go outside the building would be asked to sign an AMA form. The progress note, dated 4/7/2020 at 8:15 p.m. documented, Late Entry: Note: Around 8:15 p.m. the resident came and informed me that she was wanting to leave the facility. I contacted the director of nursing (DON) and she informed me of the process that needed to take place. I educated on the Voluntary Discharge Against Medical Advice. I explained to her that once she leaves, that she would not be able to come back to any (facility in the company). I informed her to go to her room, and process what she is doing and not go off emotions. She came to me at 10:49 p.m. and informed me that she was not leaving. I notified the DON. The progress note, dated 4/8/2020 at 7:54 p.m. documented, Note: Patient signed her voluntary AMA paper at 10:10 a.m Patient was explained the facility policy on going AMA. DON notified of patients leave. Patient exited the facility at 11:00 a.m. Walked out of front door with some belongings. The voluntary discharge against medical advise form was dated 4/8/2020 at 10:10 a.m. The form was signed by the resident. On the two witness lines were two signatures by the same person. The signature was unable to be identified as to whom it belonged to. The facility failed to provide the resident with necessary medications, failed to notify the provider at the time of discharge, and failed to ensure a safe location upon discharge. C. Interviews Resident #3 was interviewed on 4/20/2020 at 10:30 a.m. She said she was forced to sign the AMA paperwork on 4/8/2020 when she wanted to leave the facility to go to a store. She said she was told the night before on 4/7/2020, if she left the facility, she would have to sign AMA paperwork and would not be allowed into another (corporation) building. She said when she was never told on 4/7/2020 she would not be given her medications. Resident #3 was interviewed on 4/20/2020 at 1:02 p.m. She said she had called her provider on 4/9/2020 to get her medications refilled and to set up a follow up appointment. She said she was never offered a 14 day quarantine if she left. She said if she had been offered a 14 day quarantine, she would have taken it. She said she went to the homeless shelter when she left the facility. The social services director SSD was interviewed on 4/20/2020 at 10:50 a.m. She said medications are given medications when they discharge. She said the provider was notified when a patient was discharged , and usually on a normal discharge, there was a physician's orders [REDACTED]. SSD said the facility provided education to the residents at an emergency resident council meeting to discuss the changes with the pandemic. She said individuals who were not able to get to the meeting, the staff would go to each room and educate each resident. She said it had not been documented which residents had been educated. She said the education given to 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.

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) residents was about the governors stay at home order. She said the residents were asked not to leave the building. She said if a resident left the building, they would have to be screened before re-entry. She said the facility let all the residents know if they needed anything purchased, her or the activity staff would go to the store to purchase items. She said she was told about the AMA discharge when she returned to work the next day. She said she was told AMA discharged residents did not get their medication, that it was a company policy. She said she did not know where the resident left to, but she thought it could have been a hotel or a homeless shelter. She said she did not know if the provider was notified or if a follow up appointment was scheduled. The nursing home administrator (NHA) was interviewed on 4/20/2020 at 11:14 a.m. She said the facility tried to plan all the discharges from the facility to include medications, physician's follow up appointment, and anything that would go with it such as therapy or home services. She said the facility had an emergency resident council meeting to educate the residents about the pandemic, the stay at home orders, not allowing visitors, and face mask usage. She said if a resident was not at the meeting, a staff member would go door to door to educate them. She said the facility asked the residents not to leave, that if a resident needed anything to let the activities staff know or social services staff know. She said residents were allowed to go outside as long as they stayed on the facility property. She said at that time if a resident were to leave the facility, the resident would be considered AMA. She said it was the policy not to give medications upon AMA discharge. She said she was told the resident was going to go to a hotel when she left. She said she did not know when the provider was notified, She said she was notified the day of the AMA. She said there should have been a progress note when the provider was notified. She said if the resident had been offered a 14 day quarantine, she did not think she would have chosen it. She said she would look for the specific education provided to residents, specifically Resident #3, that stated if a resident left the building they would have to sign an AMA statement and be discharged AMA. She said the resident packed up her belongings, but the facility did not give her her prescribed medications per facility policy. The director of nursing (DON) was interviewed on 4/20/2020 at 1:57 p.m. She said the facility held an emergency resident council meeting. The information presented provided education on the pandemic and the changes and impact on nursing facilities. The education included the stay at home, face masks, hand washing, and social distancing. She said if a resident had not been at the meeting, the staff went door to door to provide the education. She said the training included if any resident had any questions they could go to any administrative staff to talk and ask questions. When Resident #3 decided to leave, I encouraged her not to leave, I tried to explain to her she was safer in the building where all individuals entering and leaving were screened for her safety. I had the nurse from the previous night (4/7/2020) explain that the store she wanted to go to was closed, that if she left it would be an AMA discharge and she would have to leave. On the night of 4/7/2020 she decided to stay. On the morning of 4/8/2020 she decided to pack her belongings and go. She said the two signature lines on the AMA form should have been signed by two separate people, not one person signing both lines. She said she thought the SSD signed the form. She said the provider had not been notified that day. She said she sent the provider a text message about the AMA discharge on [DATE]3/2020, but she had not made a progress note on the notification. She said Resident #3 told her she was going to go to a hotel, that she had to leave. She said she did not document the happenings immediately. She said it was the policy of the facility not to give necessary medications when a resident discharges AMA. She said the (company) would not allow her to be admitted to another facility they owned if she chose to leave AMA. The nurse practitioner (NP) was interviewed on 4/21/2020 at 1:55 p.m. She said she was not notified until [DATE]5/2020 about the AMA discharge for Resident #3. She said when she talked to Resident #3, the resident told her she was living in a homeless shelter. She said the notes she had identified Resident #3 called her office on 4/9/2020 (the day after AMA discharge) asking for refills and scheduling a follow up appointment. She said other providers could have been notified by text on [DATE]3/2020, however she was not notified until [DATE]5/2020. She said there was not a report or a notification called on the day of the AMA discharge. D. Facility follow-up The NHA sent more information on 4/21/2020 at 4:23 p.m. The following information was not located in the resident's record. A signed written statement from the NHA included, On 4/7/2020 .This writer explained to her that we were under a stay at home order and that she would be considered leaving against medical advice. Resident stated she would do what she had to do. The statement did not include the time the NHA discussed AMA with the resident. A signed written statement from the DON included, On April 7, 2020 approximately 2000 (8:00 p.m.), the floor nurse for (Resident #3) contacted me regarding resident wishing to leave facility against medical advice. While on the phone, the nurse relayed to the resident (#3) that is she chose to leave against medical advice, she could leave with personal belongings to include any medical equipment. Resident was told she would not be able to go with medications that are provided by facility and that she would (the word have had a line drawn through it) be requested to sign AMA paperwork, she would not be able to return to a (company) facility .Then on 4/8/2020, chose to sign AMA paperwork and leave. The NHA sent an email reply on 4/22/2020 at 2:25 p.m. The email included, The medical director was notified of the discharge. Both myself and SSD were notified after she left. She chose to leave against medical advice, therefore there was no order to send medications or provide any services. Physician prescribed medication for facility administration only. She also signed Voluntary Discharge Against Medical Advice which states she was informed of her risks related to discharging against medical advice which releases the physician and facility from all responsibility for any ill effects which may result from this action.