STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065273	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTOPHER HOUSE REHABILITATION AND CARE COMMUNIT	**6270 W 38TH AVE WHEAT RIDGE, CO 80033**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide one (#1) of one resident reviewed a written bed hold notice when the resident was transferred to the emergency room . Specifically, the facility failed to advise Resident #1 in writing of the facility bed hold policy when being transferred to the emergency room for evaluation and treatment. The bed hold policy was not provided upon his transfer, or within 24 hours of the transfer. Findings include: I. Facility policy and procedure The Bed Hold Policy, revised 2014, was received from the nursing home administrator (NHA) on 5/27/2020 at 11:47 a.m. The policy documented in pertinent part, If you leave our facility for a temporary stay in the hospital, we will hold or reserve your bed as follows. If you notify us that you desire to have your bed held, you will be responsible for the applicable bed hold charges. II. Resident status Resident #1, under age 55, was admitted on [DATE]. According to the computerized physician orders [REDACTED]. The 4/30/2020 minimum data set (MDS) assessment documented the resident was independent and required no staff assistance with bed mobility, transfers, dressing, personal hygiene, toileting or eating. A brief interview for mental status (BIMS) assessment documented the resident was cognitively intact with a score of 15 out of 15. III. Record review The nursing progress notes were reviewed. The notes documented on 5/11/2020 at 12:30 a.m. The resident was complaining of nausea and vomiting, abdominal muscle pain, difficulty breathing, and pain in his pancreas. The physician was notified and ordered the resident to be sent to the hospital. At 12:45 a.m., the nurse documented the resident was alert and oriented times three (person, place and time). He walked independently to the ambulance. The nurses' notes did not document the resident was advised of the facility bed hold policy at the time of his transfer. The electronic medical file was reviewed. There was no documentation in any of the progress notes that the resident was advised of the bed hold policy. IV. Interviews Registered nurse (RN) #2 was interviewed on 5/27/2020 at 10:56 a.m. She said when a resident is transferred to the hospital she sends the order summary, labs, X-rays and resident profile. She said she did not send a bed hold policy with residents when they were transferred to the hospital. She said, It may be in our system somewhere, but I don't send that with them. The director of nursing (DON) was interviewed on 5/27/202 at 11:14 a.m. She said the nurse should send the bed hold policy in writing with the resident to the hospital. She said she was not sure of the policy at this facility, but she expected the nurse to send the bed hold information with the resident. The nursing home administrator (NHA) was interviewed on 5/27/2020 at 12:22 p.m. He said the external nurse liaison is responsible for going to the hospital and seeing a resident when they are transferred. He said they discuss the bed hold policy with the resident. Documentation was requested indicating the resident had been informed of the bed hold policy by the nurse liaison once at the hospital. The NHA said, We have looked, and the nurse liaison did not document anything regarding the resident being advised of the bed hold policy. The NHA said the resident had not returned to the facility but had left the hospital against medical advice (AMA). The facility failed to document the resident was advised, in writing, of the bed hold policy upon his transfer to the hospital.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure medications were stored in accordance with accepted professional principles, in one of two medication rooms observed. Specifically, the facility failed to ensure the door to medication room [ROOM NUMBER], which contained resident medications, was closed and locked. Findings include: I. Facility policy and procedure The Storage of Medications policy, revised April 2019, was received from the director of nursing (DON) on 5/27/2020 at 11:25 a.m. The policy documented in pertinent part, The nursing staff is responsible for maintaining medication storage, and preparation areas in a clean, safe, and sanitary manner. Only persons authorized to prepare and administer medications have access to locked medications. II. Observations and interviews On 5/27/2020 at 9:52 a.m., the door to medication room [ROOM NUMBER] was open. A stool was propped against the door to hold it open. There were no staff in sight. A female resident propelled by the area in her wheelchair. Approximately 20 to 30 bottles of medications could be observed on three shelves, and two dormitory-size refrigerators were visible. On 5/27/2020 at 9:57 a.m., maintenance assistant (MA) #1 approached the medication room. He said, This door cannot be left open for people to have access to the medicine in there. He proceeded to head towards the door to close it. On 5/27/2020 at 9:58 a.m., registered nurse (RN) #1, came out of a resident room down the hall and headed toward the medication room. She told the maintenance person not to shut the door. She said she had left it open, because I didn't know what I needed from there yet. She said she was measuring something in the resident's room. III. Staff interview The DON was interviewed on 5/27/2020 at 11:19 a.m. She said, The medication room door needs to be kept closed and locked. The nurse should not be allowing anyone in there, including the certified nurse aides (CNAs). The residents or staff could have gotten into the medication stored in there. The DON said she would be completing some follow-up education with the nurse.

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.