STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAS AT SUNNY ACRES, THE	2501 E 104TH AVE THORNTON, CO 80233

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure assessments accurately reflected resident status for one (#1) of three sample residents. Specifically, the facility failed to accurately reflect the resident's skin condition in the resident's initial minimum data set (MDS) assessment. Findings include: Cross reference F684, Quality of Care. I. Resident #1's status Resident #1, age 84, was admitted on [DATE] and discharged on [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 5/3/2020 MDS assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. She was coded as high risk for pressure ulcer development and no pressure ulcers upon admission. The residents comprehensive MDS assessment did not reflect the resident had any pressure ulcers upon admission during the lookback period. II. Record review The skin committee interdisciplinary team meeting note dated 4/30/2020 documented in pertinent part the resident was admitted with intact blisters to both the right and left heel. The resident's care plan revealed the resident had potential, and not actual pressure wounds on her bilateral posterior heels. III. Staff interviews The MDS coordinator (MDSC) was interviewed on 6/24/2020 at 12:12 p.m. He said he was responsible for completing sections A, G, I, J, L, M, N and part of O and P of the MDS assessment. Section M was the section for skin conditions. He said that when a resident admitted he looked at hospital records, therapy notes, certified nurse aide (CNA) and nursing progress notes. He said that any skin issues would be captured on a five day MDS assessment. He said he would also interview the resident to get information. He said that he had an assistant that did the short-term skilled MDS assessments and he did the long term care MDS assessments. He said Resident #1's pressure ulcers should have been documented on the MDS assessment and he did not know how it was overlooked.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the facility's discharge planning process was implemented for one (#1) out of three sample residents. Specifically, the facility failed to: -Ensure discharge plans included resident and/or resident representative's discharge preferences and instructions for resident's care were identified and documented in the medical record. -Ensure the care plan included: Addressing the resident's goals for care and treatment preferences; Document the resident's interest in, and any referrals made to the local contact agency; Identify post-discharge needs such as nursing and therapy services, medical equipment and ADL assistance; Identify needs that must be addressed before the resident can be discharged , such as resident education, rehabilitation, and caregiver support and education; Be re-evaluated regularly and updated when the resident's needs or goals change. Cross-reference F661 Discharge Summary Findings include: I. Facility policy The Discharge or Transfer policy, revised 12/18, was provided by the nursing home administrator (NHA) on 6/23/2020 at 4:00 p.m. It read, in pertinent part,It is the policy of this facility to provide the resident with a safe organized structured transfer and or discharge from the facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical and psychosocial well being. Transfer or discharge: Other Healthcare Facility (Planned): Obtain orders for discharge from physician; Keep resident/family involved with all discharge planning; Complete transfer/discharge form; Provide copies of: face sheet, advanced directives, current physician orders; Provide medications if applicable; Inventory personal belongings and ensure all belongings are accounted for. Assist resident with packing and transportation of personal items to transport vehicle; Escort resident from facility; Nursing to notify administration of discharge; and Document the entire process in the Nursing Notes. II. Resident status Resident #1, age 84, was admitted on [DATE] and discharged to an assisted living facility on 5/29/2020. According to the May 2020 computerized physician orders [REDACTED]. The 5/3/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of nine out of 15. She required extensive assistance of one to two staff members with her activities of daily living (ADLs) and mobility. The MDS revealed the resident used both a walker and a wheelchair for mobility. The resident expected to be discharged to the community and discharge planning was actively occurring for the resident to return to the community, and no referrals were needed. III. Assisted living staff and family interviews An assisted living facility staff member was interviewed on 6/23/2020 at 1:57 p.m. She stated the resident was received by the facility on 5/29/2020 in the late afternoon. She stated the nursing facility transportation transferred the resident into a chair in the lobby of the facility, took the wheelchair used to transport her, and gave the facility staff her paperwork and left. She stated the paperwork received at the facility included a face sheet, physician orders [REDACTED]. She said that the lack of instructions made it difficult to know what care that the resident needed. She said multiple calls were made to the facility for clarification but the assisted living staff were unable to reach the nursing facility. Ultimately, the assisted living facility called the resident's primary care physician for clarification of the resident's needs and care orders. A family member of the resident was interviewed on 6/23/2020 at 7:00 p.m. She stated the assisted living facility staff called her and told her the paperwork from the facility did not include instructions for care of the resident. She stated she knew the resident was set to discharge to the assisted living on 5/29/2020 from a voice message sent from the nursing facility. She stated she attempted to contact the nursing facility many times and received no response. IV. Record review The resident's discharge care plan was developed on 5/1/2020 and read the resident was admitted for a short term skilled stay and wanted to transition to long term care after the skilled stay. Interventions for the care plan were all dated 5/1/2020 and included: Establish a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise the plan. Evaluate and discuss with resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits and needs for maximum independence. Evaluate/record abilities and strengths, with family/caregivers/interdisciplinary team (IDT). Determine gaps in abilities which will affect discharge. The care plan failed to include: Addressing the resident's goals for care and treatment preferences; Document the resident's interest in, and any referrals made to the local contact agency; Identify post-discharge needs such as nursing and therapy services, medical equipment and ADL assistance; Identify needs that must be addressed before the resident can be discharged , such as resident education, rehabilitation, and caregiver support and education; Be re-evaluated regularly and updated when the resident's needs or goals change. On 4/30/2020 a social services note read the resident was admitted for a short term skilled stay in the facility and the resident would like to transition to long term care after skilled rehab. On 5/19/2020 a social services note read the writer had called the resident's daughter to inform her of the notice of Medicare Non-Coverage (NOMNC) with a last covered day of 5/21/2020. The resident transitioned into long term care until discharge. On 5/27/2020 a social services note read the writer was working with assisted living staff, family, physician and the resident to facilitate a safe transfer to the assisted living later that week. However, the documentation failed to include the resident and/or resident representative's preference for discharge to an assisted living facility. The 5/29/2020 discharge packet included a copy of the resident's face sheet, vitals dated 5/27/2020 that was two days prior to her discharge, a list of her medications, care plans and power of

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 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) attorney paperwork. The packet did not include a discharge summary, instructions or any description of the discharge plans. Review of the resident's medical records on 6/24/2020 revealed no documentation from the interdisciplinary team (IDT) related to the resident's discharge planning including the specific details and services initiated upon discharge. There was limited documentation related to the involvement of the resident and/or resident representative, and the assisted living facility. V. Interviews The social services assistant (SSA) was interviewed on 6/23/2020 at 3:45 p.m. She stated that she was not the social worker assigned to the resident's discharge planning process. She stated the social worker assigned was not available for an interview since she was on vacation. She stated discharge planning began upon a resident's admission. She stated discharge plans were discussed with family at the initial care plan meeting which occurred within 72 hours of admission. She stated the social workers were talking to families so often, it was difficult to document every conversation. She said there should be documentation of discharge planning when the resident planned to leave the facility in the medical record. The social services director (SSD) was interviewed on 6/23/2020 at 3:55 p.m. She stated there should have been documentation of the conversations and plans related to the resident's discharge in the medical record. Registered nurse (RN) #2 was interviewed on 6/24/2020 at 9:39 a.m. She stated the nurses were informed about discharges by the social services department. She stated the discharge packet and paperwork were prepared by the social workers and the nurses used the information given to them to get the resident discharged . She stated the process for discharging residents was to do a skin assessment and a set of vital signs. She said the discharge medications and instructions were discussed with the resident and representative, if present, and the resident or representative signed a paper stating discharge instructions were understood. She stated a discharge note should be written for each resident who discharged that document at minimum the resident's condition upon discharge, the time they left, and how they were transported. RN #1 was interviewed on 6/24/2020 at 9:47 a.m. She stated when a resident discharged there should be a note written by the nurse who completed the discharge. She stated the note should include where the resident discharged to, how they were transported, the time they left and the resident's condition upon discharge. She stated the note should also include a description of the medications and instructions given to the resident. The NHA was interviewed on 6/24/2020 at 12:13 p.m. He stated he would expect the staff in both the social services department and the nursing department to follow the discharge policy and procedure. He stated all discharge planning should be documented and should show the coordination between the facility staff, the resident's representative and the receiving facility. He stated there should be documentation related to all aspects of the discharge that specifies what the plans were and how the plans were carried out including services that were arranged upon discharge.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a discharge summary was developed and provided to the receiving facility upon the discharge of one (#1) out of three residents reviewed. Specifically, the facility failed to: -Ensure the discharge summary included: An accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions including all special instructions or precautions for ongoing care, as appropriate; and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care; -Ensure that care was coordinated and the resident transitioned safely from one setting to another to ensure that the discharge summary reduced or eliminated confusion with the receiving facility, agencies, practitioners, and caregivers involved with the resident's care; and Ensure that the receiving facility would be able to provide appropriate and timely care; -Ensure the discharge summary was furnished in either hard copy or electronic format to prevent delays in coordination required to provide optimal care to the resident. Cross-reference F660 Discharge Planning Process Findings include: I. Resident status Resident #1, age 84, was admitted on [DATE] and discharged to an assisted living facility on 5/29/2020. According to the May 2020 computerized physician orders [REDACTED]. The 5/3/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of nine out of 15. She required extensive assistance of one to two staff members with her activities of daily living (ADLs) and mobility. The MDS revealed the resident used both a walker and a wheelchair for mobility. The resident expected to be discharged to the community and discharge planning was actively occurring for the resident to return to the community, and no referrals were needed. II. Record Review The discharge summary, dated 5/28/2020, read the resident was to discharge to the assisted living facility on 5/29/2020. The summary referred to the review of the resident's Medication Administration Record [REDACTED]. The summary read that the resident was in stable condition for discharge. The discharge summary included a recapitulation of the resident's stay at the facility. The discharge summary failed to include: An accurate and current description of the clinical status of the resident which was sufficiently detailed, individualized care instructions including all special instructions or precautions for ongoing care, as appropriate; and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care; ensure that care was coordinated and the resident transitioned safely from one setting to another to ensure that the discharge summary reduced or eliminated confusion with the receiving facility, agencies, practitioners, and caregivers involved with the resident's care; and ensure that the receiving facility would be able to provide appropriate and timely care. The 5/29/2020 discharge packet that was sent to the receiving facility, included a copy of the face sheet, vitals dated 5/27/2020 which was two days prior to discharge, care plans and power of attorney paperwork, physician orders [REDACTED]. The discharge packet failed to include progress notes, an instruction sheet for care of the resident, and the discharge summary. III. Interviews An assisted living facility staff member was interviewed on 6/23/2020 at 1:57 p.m. She stated when the resident arrived at the assisted living facility, the paperwork received from the nursing facility did not include a discharge summary or clear instructions for the resident's care, medications or treatments. She stated multiple attempts to contact the nursing facility were made with no success, so ultimately the resident's primary care physician was contacted. The nursing home administrator (NHA) was interviewed on 6/24/2020 at 12:13 p.m. He stated the discharge summary should be included with the discharge packet for the resident, representative and receiving facility. He stated all aspects of a resident's discharge should be clearly documented and the discharge summary should be included.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the care provided to one (#1) out of three sample residents met professional standards of care. Specifically, the facility failed to ensure Resident #1 received daily pressure ulcer treatment as ordered by the physician. In addition, the facility failed to ensure an accurate care plan was in place that reflected her pressure ulcer status upon admission. Findings include: I. Facility policy The Care and Treatment Related Medication Orders policy, revised 3/19, was provided by the nursing home administrator (NHA) on 6/25/2020 at 8:00 a.m. The policy documented in pertinent part, Medications are administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. The licensed employee must follow all orders as given by the prescriber. Each medication administered is documented in the resident's medical record on the electronic Medication Administration Record [REDACTED]. II. Resident #1's status Resident #1, age 84, admitted on [DATE] and discharged on [DATE]. According to the May 2020 computerized physician's orders [REDACTED]. The 5/3/2020 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. She required limited assistance with bed mobility, extensive assistance with transfers and extensive assistance with toileting. She was frequently incontinent of bowel and bladder function. III. Record review The May 2020 CPO documented in part the following pertinent orders: - Weekly skin evaluation; Friday, every day shift; - Apply barrier cream to coccyx/sacrum and bilateral buttocks every shift; - Apply skin protective wipe to bilateral heels every shift for skin care; - Float heels in bed every shift for skin care; - Pressure relieving boots to both feet at all times as tolerated, every shift for wound care; - Pressure reduction mattress; - Left heel pressure wound: Cleanse with wound cleanser, pat dry, apply silver gel to wound bed and cover with dry dressing daily. Order date 5/17/2020. The skin note dated 4/30/2020

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) documented in pertinent part the resident had a right and left heel blister upon admission that were both intact. The care plan, initiated 4/30/2020, documented in part, the resident had potential for pressure ulcer development related to decreased mobility. The goal read that she would have intact skin, free of redness, blisters or discoloration through the review date. Interventions included in part, to administer medications as ordered, apply barrier cream as ordered, educate resident, family/caregivers as to causes of skin breakdown, float heels, follow facility policies/protocols for the prevention/treatment of [REDACTED]. - The care plan failed to document the resident had bilateral heel pressure injuries with blistering upon admission per the 4/30/2020 note above. In addition, the care plan was not updated to reflect any treatment orders. The daily skilled nurse note dated 5/17/2020 documented in part the resident's left heel was now open. The note documented the left heel blister had a small amount of serous drainage. The May 2020 treatment administration record (TAR) revealed the following order: Left heel pressure wound: Cleanse with wound cleanser, pat dry. Apply silver gel to the wound bed and cover with dry dressing daily every day shift for wound care. There were a total of five treatment omissions as evidenced by no nurse signature for four consecutive days (5/22/2020, 5/23/2020, 5/24/2020 and 5/25/2020). In addition, a fifth day 5/28/2020 was also blank. The omission of nurse initials for these dates demonstrated that the above physician's treatment orders were not followed. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 6/23/2020 at 3:28 p.m. She said that she was responsible for doing weekly skin assessments of residents and then documenting them in the EMR. She said if a resident had a change of condition (COC) involving their skin, she would open up a risk management tool and fill out all the pertinent information. She would then talk to the resident to ask them if they knew how they might have obtained the injury. She would then do a full skin assessment and notify the physician, family and also the wound nurse (WN). She said treatments and medications should be signed off when completed. LPN #2 was interviewed on 6/23/2020 at 3:30 p.m. She said she was responsible for doing weekly skin assessments and also skin treatments. She said the best time to check a resident's skin was on their shower days. She said she checked them from head to toe and if she saw anything abnormal or new she would let the physician and WN know. She said that all changes should be documented in a progress note and all physician's orders [REDACTED].#3 was interviewed on 6/23/2020 at 3:48 p.m. She said she was responsible for doing weekly skin assessments and usually did them when the certified nurse aides (CNA) had a resident in the shower. She said she also completed skin treatments. She said if she noticed any concerns she would notify the physician and WN. She said she would also measure any wounds and put that information in a progress note. She said she would document in the TAR when she had completed a treatment. She said she always signed off when she had done a treatment although she might not get to it right away if she was busy. CNA #2 was interviewed on 6/24/2020 at 9:40 a.m. She said that she provided skin care to residents with personal care and after their showers. She said she used a skin barrier cream as a preventative measure to assist with skin breakdown. She said if she noticed any changes in a resident's skin she would report it to the nurse right away. She said she would also document any concerns on the shower sheet and place it in the shower binder. She said she did not remember the resident and she was answering to the standard of practice by CNAs. CNA #1 was interviewed on 6/24/2020 at 9:58 a.m. She said that if she noticed any skin injuries, like bruising or rashes during resident care she would alert the nurse right away and both she and the nurse would look at it together. She said they used shower sheets to mark on if a resident had any reddened areas or any breakdown and then she would give it to the nurse to sign off on. She said she would then document in the computer and write a custom note about the change. She said she remembered Resident #1 although she did not take care of her except to give her a shower one time. She said the resident needed assistance to transfer to the wheelchair and that she was incontinent of both bowel and bladder. Registered nurse (RN #1) was interviewed 6/24/2020 at 10:05 a.m. She said that anytime a resident had a skin change of condition she would open up an event report and do a full assessment. She said the event report prompted nurses to do a Braden skin risk assessment scale and to notify the physician and family. She said she would then place any new orders given by the physician into the EMR and let the WN know. She said she completed skin assessments per facility policy if they came up on her scheduled work days. She said the skin assessments required an explanation of any skin condition and treatments being done. She said that treatments were documented on the TAR in the EMR and she would sign off on them as soon as she did them. She said that the orders popped up on the EMR when they were scheduled to be done and that all orders must be followed as written. The WN was interviewed on 6/24/2020 at 11:00 a.m. She said the admitting nurse would complete the initial skin assessment and input any orders at that time. She said that she would follow up with a resident after admission if there was any skin issues and do her own assessment and measuring of the wound. She said she would then see residents with wounds on a weekly basis. She said the nurses were allowed to do measurements but they could not stage a wound. She said that the more thorough skin assessments are done weekly and if they were on skilled care the nurse will also do a brief daily skin check. She said that Resident #1 was admitted with intact blisters to both heels. She said at the beginning interventions were put in place to include a specialty mattress, floating her heels and then protective booties. She said skin prep was being applied to the wounds at first to try and keep them intact. She said that blisters were considered a stage two pressure ulcer. She said as far as she could remember, the resident did not have any open areas to her bottom. She said the CNAs used barrier cream as a preventative measure to ensure no skin breakdown occurred on residents' bottoms. She said Resident #1's heel wounds were getting better with treatment even after the left heel blister opened up on 5/17/2020 and it was a stage 2 pressure ulcer. She said that physician's orders [REDACTED]. She said that if there were missing signatures on the TAR, there was no way to confirm the treatment had been done.