STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065367	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE CARE AND REHABILITATION CENTER, THE	9221 WADSWORTH PKWY WESTMINSTER, CO 80021

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative interview and staff interviews, the facility failed to notify the resident's legal representative of a change in condition for one (#1) of three sample residents. Specifically, the facility failed to notify Resident #1's representative when changes in behaviors occurred, decreased appetite, medication dosage change and when a new pain medication was ordered for Resident #1. Findings include: I. Facility policy and procedure The Acute Condition Changes Clinical protocol policy, revised March 2018, was provided by the interim nursing home administrator (INHA) on 8/13/20 at 2:30 p.m. It read in pertinent parts, direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the nurse. The nursing staff will contact the physician based on the urgency of the situation. -The policy did not include legal representative notification. II. Resident status Resident #1, age 77, was admitted on [DATE] and was discharged on [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 5/7/20 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments. The MDS identified the resident's speech was clear but she was unable to make herself understood. A brief interview for mental status (BIMS), was not completed due to cognitive impairments. The resident required extensive assistance from staff with bed mobility, transfers and limited assistance with eating. III. Record review A. Progress notes The progress note dated 5/5/2020 documented: the resident was very tearful today, the patient had a very poor appetite. The progress note dated 5/6/2020 documented: resident restless and agitated this night until midnight. Resident needed extra reassurance and care to take medication. Resident was verbalied she needed to get out of here and go home to her father sitting on the edge of the bed. Not wanting to lie down. Resident was groaning, and facial grimacing when this writer assisted the resident to sit up. As needed(PRN) Tylenol was administered. The progress note dated 5/7/2020 documented resident is tearful at this time, unable to redirect/reassure resident. Appetite fair, needs to be fed by certified nurse aide(CNA). The progress note dated 5/10/2020 documented: appetite and fluid intake fair with one person assistance with feeding. Resident with an episode of tearing up and crying. Able to redirect at times, CNA in the resident's room throughout the day sitting with the resident and offering reassurance and redirection. The progress note dated 5/10/2020 documented: resident tearful at times. Appetite fair, resident need to be fed by CNA. The progress note dated on 5/12/2020 documented: resident appetite and fluid intake are very poor, supplement offered, resident refused. Resident needed one person's assistance with feeding. Resident groans, moans and holler out. Resident has issues articulating words, the resident does not communicate her needs, the resident slides down in her wheelchair during the day. The facility failed to notify Resident #1 legal representative of changes in condition documented above. B. Physician orders [REDACTED]. The TO dated 5/8/2020 included: Discontinued (D/C) Tylenol current order. Tylenol 500mg tablets, give two tablets by mouth three times a day (TID) and [MEDICATION NAME] (narcotic medication) 25mg every six hours as needed for pain. Resident #1's Tylenol was increased from 2000mg daily to 3000mg daily and a new pain medication [MEDICATION NAME] 25mg was ordered. The facility failed to notify the Resident #1's legal representative when pain medication changes were made and when a new pain medication was ordered for the resident. IV. Resident representative interview On 8/12/2020 at 10:37 a.m., the resident legal representative was interviewed. She said her mother lived at the facility for about two weeks. She said the facility did not notify her and her dad that her mother had a decreased appetite. She said the facility gave her mother pain medication and did not notify them. She said there had been poor communication with facility staff . She said her mother had never taken [MEDICATION NAME], she said the facility ordered [MEDICATION NAME] and administered it to her mother and did not notify them. She said her mother was a thin woman and she believed the pain medication made her lethargic and she believed that was why her mother was not eating. She said the facility staff did not notify them of the changes in her behaviors. She said she was upset because of the poor communication with facility staff. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/13/2020 at 10:30 a.m. She said the policy was to notify the resident representative of any change in condition such behaviors, abnormal x-rays and medication changes. She said for behavior changes, the nurse documented in the progress note that the resident representative was notified. She said for medication changes or new medication orders, the nurse notified the resident representative and it was documented on the physician's orders [REDACTED].#1's legal representative was notified of her change in condition when she was in the facility. She said it had been three months since the resident was discharged from the facility. She said if the nurse had notified Resident #1's legal representative, it was documented in the progress note or physician order. Registered nurse (RN) #1 was interviewed on 8/13/2020 at 11:00 a.m. She said she was the nurse supervisor. She said if a resident had a change in condition such as falls, decreased appetite, behaviors or medication changes, the nurse notified the resident's legal representative and documented it in the progress note. She said sometimes they would notify the legal representative verbally when they were at the facility. She said for medication changes and new medications orders, the nurse would notify the resident's legal representative and document it on the physician orders. She said she did not remember Resident #1 because it had been three months since the resident was discharged from the facility. She said if the resident's legal representative was notified, it should be documented in the progress notes or the physician orders.

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.