STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065416	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Northridge, Llc, The	12285 Pecos St Westminster, CO 80234

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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 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 interviews and record review, the facility failed to develop and implement an effective discharge planning process focussing on the resident's discharge goals for three (#76, #47 and #64) of five residents reviewed for discharge planning out of 38 sample residents. Specifically, the facility failed to for Resident #76, Resident #47 and Resident #64: -Involve the resident and the resident's representative in the discharge plan; and, -Develop discharge care plan with appropriate goals and approaches. Findings include: I. Facility policy and procedure The Admission, Discharge and Transfer policy, revised 2/9/23, was provided by the nursing home administrator (NHA) on 4/2/24 at 12:31 p.m. It read in pertinent part: Regardless of payment method, all residents have access to: Care that is timely and meets the needs of the resident; access to their physician; Staff, including administrative staff; and Care-planning and discharge-planning processes. Staff involved in the move in, transfer and move out process will ensure that the focus is the resident and their family and their needs and concerns. Facility staff will assist the resident and/or representative in making appropriate arrangements for the discharge of the resident when it is determined that the facility can no longer meet the needs of the resident, the resident is a danger to themselves or others, or has not paid for their stay after receiving notice meeting the above-mentioned criteria. When the physician and resident determine that moving to another facility or home is appropriate, facility staff will assist the resident and/or surrogate decision- maker and family to plan for the care and services to ensure continuity of care. II. Resident #76 A. Resident status Resident #76, age [AGE], was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), the diagnoses included acute osteomyelitis of left foot and ankle, type two diabetes and muscle weakness. The 3/12/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive (continued on next page)

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment with a brief interview for mental status (BIMS) score of 11 out of 15. She was independent or required supervision with activities of daily living (ADL). B. Resident interview Resident #76 was interviewed on 3/27/24 at 4:27 p.m. Resident #76 said she was told she had to move out of the current facility because she had exceeded her benefits and she was moving to an assisted living while home repairs were being completed. Resident #76 said there was a broken sewer line at her house that had caused a lot of damage and was more than she could manage. The resident said she was at the current facility for help managing her insulin and an infection needing antibiotics administered through her arm (intravenously). Resident #76 said a placement agent had helped her find assisted living and she knew her before she was admitted to the current facility. Resident #76 said the placement agent and her two friends were the only people helping here with discharge planning. Resident #76 said she was signing admission paperwork for assisted living on 3/28/24 and would only be staying there until her home renovation was complete. C. Record review The discharge care plan, initiated on 3/6/24, revealed Resident #76 wanted to establish goals for herself and be involved in her discharge planning. It indicated the resident would discharge to the highest optimal level of care over the next 90 days. Pertinent interventions included Resident #76 wanted to go home when she was discharged , communicating with the patient and/or family as needed related to progress, goals and plans and encouraging the patient to make an effort toward achieving their goals. -The care plan failed to identify Resident #76 would discharge to assisted living, was working with a placement agency to achieve this goal and if returning home was attainable. The 3/8/24 progress note revealed a care conference occurred discussing discharge, therapy and plan of care, in attendance was Resident #76, case manager (CM) #1, two friends of Resident #76, a member of the therapy department and the primary care physician. It indicated Resident #76 was living at home alone and staying at an extended stay hotel due to home renovations and Resident #76 was working with a company for discharge options. Resident #76 was advised by CM #1 to take all valuables home as they would not be needed in the facility and the facility would not be financially liable for any lost or missing property. Resident #76 was educated by CM #1 the typical length of stay was three weeks. CM #1 informed those present to bring in clothing for the resident and provided contact information for any further questions or concerns. The 4/1/24 progress note (during survey process) indicated Resident #76 had been issued a notice of medicare non-coverage (NOMNC) and the last coverage day (LCD) was 4/3/24 and Resident #76 would discharge to an assisted living on 4/4/24. Resident #76 was educated on her right to appeal and waived this right. III. Resident #47 A. Resident status (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47, age [AGE], was admitted on [DATE]. According to the April 2024 CPO, the diagnoses included fracture of the neck and right femur. The 3/3/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She required moderate assistance of one staff member for transferring, toileting and personal hygiene. B. Resident and resident representative interview Resident #47 and the resident representative were interviewed on 3/27/24 at 3:07 p.m. The resident representative said Resident #47 spent time living between her and her sister's home. She said there was a lack of communication happening with the discharge plan for Resident #47. She said she and her sister had been informed CM #1 would be the contact person for discussing discharge planning during a care conference at admission. She said she and her sister were leaving town for a family event and had left messages for CM #1 but had not heard back. Resident #47's representative said not having communication was stressful. Resident #47 said she was planning to return to her prior living arrangements between both homes. Resident #47 said she did not know who her CM was at the facility or if she had one. C. Record review The discharge care plan, initiated on 2/27/24, revealed Resident #47 wanted to establish goals for herself and be involved in the discharge planning process. It indicated the resident would discharge to the highest optimal level of care over the next 90 days. Pertinent interventions included Resident #47 wanted to go home, to an assisted living or to a long term care community when she was discharged and communicating with the patient and/or her family as needed related to progress, goals and plans. The 2/28/24 progress note revealed a care conference occurred discussing discharge, therapy and plan of care, Resident #47, CM #1, Resident #47's resident representative, a member of therapy and the primary care physician were in attendance. It indicated Resident #47 lived between the home of two daughters and the plan for discharge was to return to the prior living arrangement. CM #1 advised Resident #47 and family to take home all valuables as they were not needed in the facility and the facility would not be financially liable for any lost or missing property. CM #1 informed the Resident a typical length of stay was three weeks. CM #1 informed those present to bring in clothing for the resident and provided contact information for any further questions or concerns. The 4/1/24 progress note revealed (during the survey) CM #1 had spoken to Resident #47's resident representative to discuss a 4/6/24 discharge date and a care conference had been scheduled for 4/2/24 at 2:00 p.m. including therapy and the progression Resident #47 had made. -The care plan failed to identify returning home as the resident and the preferred discharge location. IV. Resident #64 A. Resident status (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #64, age over 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included acquired absence of the right leg below the knee, type two diabetes (insulin resistance), muscle weakness and chronic heart failure. The minimum data set (MDS) assessment from 3/7/24 documented this resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. This resident was dependent on assistance for activities of daily living (ADL) and transfers. B. Resident and representative interview Resident #64 and her representative were interviewed on 3/28/24 at 12:50 p.m. The resident said she received paperwork about her discharge. She said she was not sure where she was going and was scared they were going to send her back home, where she did not have the support to take care of herself. The resident's representative was assisting her in the discharge process. He said he had a senior blue book and was looking for options for Residents #64's discharge because her home was not equipped for a wheelchair and he did not have adequate support for her to excel at home. He knew she needed more care and he said the case managers only gave him resources for him to find on his own. He said he was stressed and worried about the resident getting sent back home and not having the assistance she required at home. C. Record review The progress note from 3/7/24 documented there was a care conference held to discuss discharge planning and therapy goals. The discharge plan was to return home at this time. The progress note on 3/20/24 documented case management met with the resident's husband regarding discharge plans. The husband had started looking for a long term care facility for his wife and he had a Senior Blue Book (resources for aging population). V. Staff interviews Occupational therapist #1 was interviewed on 3/28/24 at 3:41 p.m. She said it was not safe for Resident #64 to go home. She said the therapy department knew right away from the initial evaluation she would not be able to go home. She said Resident #64 was being discharged because she had plateaued on her therapy goals and it was unlikely she would progress. Social services assistant (SSA) #1 and SSA #2 were interviewed on 4/1/24 at 12:05 p.m. SSA #1 said care conferences typically happened on the second day of admission and involved discussing the primary discharge plan and discussing alternatives if the primary discharge plan was not attainable. SSA #1 said residents, families, resident representatives, therapy staff and primary care physicians were in attendance. SSA #1 said discharge discussions were held weekly with residents, families and resident representatives and conversations were documented in the electronic medical record. SSA #1 said nursing initiated the baseline care plans to include the discharge planning focus, goals and interventions. SSA #1 and SSA #2 said it was the responsibility of the social services department to coordinate discharge planning. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSA #2 said care plans were reviewed and revised every 21 days and more if needed. SSA #2 said changes with discharge location were considered a reason for revising a discharge care plan. SSA #1 said she was assigned to Resident #76 and Resident #47. SSA #1 said she had spoken to Resident #76 a couple of times since her admission and the discharge plan had always been to admit to assisted living. SSA #1 said a placement agent who worked for the company the resident was utilizing had been assisting Resident #76 with discharge planning. SSA #1 said the discharge plan for Resident #47 had always been to return to her prior living arrangements between each daughter's home. SSA #1 said she had spoken with Resident #76's power of attorney (POA) weekly. SSA #1 was unable to provide documentation of conversation or topics discussed. SSA #1 said she could not recall the last time she had spoken to Resident #47 or daughter's about the discharge plan. SSA #3 was interviewed on 4/2/24 at 9:18 a.m. She said Resident #64's discharge planning began at her initial care conference on 3/7/24. She said the resident's medical power of attorney (MDPOA) was hopeful the resident would return home at the time of the initial care conference. She said immediately when the resident began working with therapy, the care team knew she would not progress to return home. She said the plan to return home was not realistic so there was nothing done to plan for that discharge route. She said more conversations with residents and representatives should be occurring. The minimal data set coordinator (MDSC) was interviewed on 4/2/24 at 10:17 a.m. She said the baseline care plan should be completed within seven days but no longer than 21 days after an admission and the social services department was responsible for completing the discharge care plan and ensuring accuracy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on record review and interviews, the facility failed to ensure the safety and supervision to prevent accidents for one (#66) of three residents reviewed for falls of 38 sample residents. Specifically, the facility failed to ensure Resident #66 was safe while ambulating with therapy. Findings include: I. Facility policy and procedure The Fall Prevention policy, revised October 2017, was received from the nursing home administrator (NHA) on 4/2/24 at 12:31 p.m. The policy documented in pertinent part, The post fall procedure includes nursing to assess the patient and determine the most appropriate course of action. Notification of the following must take place: physician, responsible party, and director of nursing (DON). Risk management was to be completed. Determine what interventions needed to be implemented to prevent further falls, and complete orders and/or tasks for fall prevention and for further skin injuries if indicated. II. Resident #66 status Resident #66, age under 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included peritoneal abscess (infection in the lining of the abdominal cavity), Crohn's disease (swollen and irritated digestive tract), muscle weakness and difficulty in walking. According to the 2/27/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. It was documented that this resident was a substantial/maximal assistance for chair to bed transfers, toilet transfers, and lying to sitting on the side of the bed. III. Resident interview Resident #66 was interviewed on 4/1/24 at 12:30 p.m. She said she fell while working on the stairs in the therapy gym on 3/26/24. She said she got tired and her knees buckled under her body and she fell down, scraping her right knee on the stairs. She said two days later, on 3/28/24, she was working with the same therapist. She was walking to the elevator with the therapist following behind with her wheelchair. She said when they got to the elevator, the wheelchair was no longer behind her and the therapist went to press the elevator button. The resident said she fell backward and did not remember the fall. She said nursing staff came over to assess her and she was sent to the hospital. She said she sustained a bruise and gash on the back of her head. She said she was taking pain medication for it. IV. Record review The nursing note from 3/26/24 documented therapy reported to the nurse the resident had fallen to her knees while doing the stairs in the therapy gym. The resident was witnessed and assisted into a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. There was a small abrasion to the resident's right knee. The resident was assessed by the nursing staff and assisted back to her room. The post fall assessment documented on 3/26/24 recommendations from the interdisciplinary review team included therapy to assess resident's need for a support device to the right knee. The nursing note from 3/28/24 documented a therapist was walking the resident to the elevator. The resident lost balance and fell backwards on the floor, hit the back of her head, and sustained a laceration and was bleeding. The resident was on anticoagulant (blood thinner) medication and she was sent to the hospital for further evaluation. The post fall assessment documented on 3/28/24 recommendations from the review team included educating physical therapy on transitioning into the elevator and holding the gait belt while getting on the elevator. -However, education was not provided until 4/2/24 after brought to the facility's attention (see below). According to the hospital record from 3/28/24, it was documented the fall was most likely attributed to resident debility/deconditioning. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/1/24 at 12:40 p.m. She said Resident #66 required one assist for transfers. She said this meant one person would be there to assist this resident using a gait belt and holding onto the belt. She said she only assisted with transferring from the bed to the wheelchair and the therapy department were the only staff who walked with her. Registered nurse (RN) #1 was interviewed on 4/1/24 at 12:50 p.m. He said Resident #66 required one person to assist with transfers. He said this meant one person used a gait belt and would hold onto the belt during the transfer. He said she used a front wheeled walker and a wheelchair. Physical therapy assistant (PTA) #1 was interviewed on 4/1/24 at 3:08 p.m. PTA #1 said Resident #66 was a contact guard on the stairs, meaning the PTA had her hands on the resident at all times. PTA #1 said Resident #66 was working on the stairs on 3/26/28 in the therapy gym and fell onto the stairs. The resident was wearing a gait belt and the PTA was holding onto it. PTA #1 said Resident #66 was a stand by assist for walking, which meant the therapist had to be within arm's reach to prevent a fall. PTA #1 said she was working with Resident #66 two days later and they walked to the elevators together. PTA #1 was following behind the resident with a wheelchair and the resident was walking with a walker. The resident was wearing a gait belt. They got to the elevator and PTA #1 set the wheelchair beside the resident. PTA #1 walked over to press the elevator button and when she looked back at the resident, the resident was falling backward. She said the resident fell straight back and hit her head on the ground. She said the nursing staff came to assess the resident and the resident was sent to the hospital. VI. Facility follow-up PTA #1 was provided education on 4/2/24 regarding downgrading Resident #66 to contact guard (placing one or two hands on the resident's body to help with balance) during walking and transitioning to (continued on next page)

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