STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to provide and document sufficient preparation and orientation to one (#191) of three out of 53 sample residents to ensure a safe discharge from the facility. Specifically, the facility failed to provide evidence and documented confirmation that home health services were arranged upon Resident #191's discharge from the facility, per physician orders. Findings include: I. Facility policy and procedure The Discharge Planning Process policy and procedure, revised December 2023, was provided by the nursing home administrator (NHA) on 3/11/24 at 4:09 p.m. It read in pertinent part, The discharge process should effectively transition them to post-discharge care, and minimize clinical or other factors which are related to the possibility of a readmission. The facility's discharge planning process shall provide and document sufficient preparation. II. Resident #191 status Resident #191, age 73, was admitted on [DATE], and discharged on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included cellulitis (bacterial infection of skin) of right lower limb, type 2 diabetes mellitus, and acquired absence of left leg below the knee (amputation). The 2/4/24 discharge minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximal assistance with toileting hygiene, shower/bathing, upper and lower body dressing, personal hygiene, and transfers lying to sit. She was dependent on the use of a manual wheelchair for mobility. A. Resident representative interview (continued on next page)

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.

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

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative (RR) was interviewed on 3/12/24 at 1:37 p.m. She said that Resident #191 was discharged home alone on 2/4/24 without home health (HH) services in place. The RR said she was not aware that the HH company did not accepted the facility's referral until the day after Resident #191 had been discharged (2/5/24). The RR said on the day (2/4/24) of Resident #191's discharge, the nurses had advised her that home health services were not set up, only a physician's order. RR said she received an email from the social services assistant (SSA) that morning saying she had sent a referral to a home health agency for PT (physical therapy), OT (occupational therapy, and RN (Registered nurse). The RR said the SSA had failed to make personal contact with the home health company to confirm the resident had been accepted. The RR said the facility did not follow physician orders to provide home health services at discharge. She said the resident especially needed a home care nurse to provide wound care to the right calf. The RR said she had to perform the wound care even though she had no medical training or education from the facility. The RR said on Tuesday (2/6/24), two days after the resident discharged home, Resident #191 had a fall and sliced her right leg. The RR said that emergency services had taken Resident #191 to the emergency room where she had to have eight stitches. The RR said without home health care confirmed and in place, it was an unsafe discharge for Resident #191. The RR said the SSA did not ensure a safe discharge and placed Resident #191 in an extremely unsafe situation. The RR said she had to look for a home health agency on her own. She said that the agency started care on 2/19/24. The RR said Resident #191 was home without home healthcare for 15 days. B. Record review The discharge care plan, initiated 11/12/23, revealed the resident planned to return home where she lived alone in an apartment. The interventions included encouraging the resident to discuss feeling and concerns with an impending discharge; establishing a pre-discharge plan with the resident, family/caregivers; evaluating the progress and revising the discharge plan as needed; evaluating the resident's motivation to return to the community; evaluating and recording the resident's abilities and strength, with family/caregivers/IDT (interdisciplinary team); determining gaps in the resident's abilities which will affect discharge; making arrangements with required community resources to support independence post-discharge; and preparing and giving the resident, family member and caregiver contact numbers for all community referrals. A review of the CPOs dated 1/30/24 revealed Right posterior calf wound. Cleanse with wound cleanser, apply collagen powder to wound bed, cover with foam dressing; change three times per week. A review of the PT home evaluation note on 1/31/24 revealed, Reviewed with team patient's improved level of functional mobility but need for some home health services to optimize safety and carryover. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the OT home evaluation note on 1/31/23 revealed, Reviewed with team patient's improved level of functional mobility but need for home health services to ensure safety and carry over in the home. A review of the CPOs dated 2/1/24 revealed Discharge is scheduled for 2/4/24 to return home. Home health care will provide PT, OT, RN. Send with belongings. An email sent to the RR from the SSA on 2/4/24 at 9:07 a.m. documented, Referral sent to (company name) Home Health Care, will provide PT, OT, RN for home health care needs. -However there was no documentation provided that the home health company had received, accepted and was able to staff the referral. A review of a text message sent from the RR to assistant nursing home administrator (ANHA) on 2/4/24 at 9:58 a.m. revealed, Resident #191 is set to discharge at 1:30 p.m. today. Nurses have advised there is nothing set up for home health care only a Dr. (doctors) orders. A review of the facility's physician discharge summary, dated 2/4/24 at 9:23 a.m. revealed in pertinent part, Disposition: Discharge to home with home health. History of present illness: Patient discharged to SNF (skilled nursing facility) and then to home with wound vac. However home health care was not successfully arranged. Rehabilitation process: Resident #191 has achieved the desired rehabilitation goals and collectively deemed safe to transition home with health services. I certify that home health services are medically necessary as the patient is expected to be relatively homebound and any initial trips away from home will require considerable taxing efforts and subsequent office appointments with you or a specialist. Documentation was requested from NHA on 3/7/24 at 11:53 a.m. for the preferred home health referral from the facility (social services department), and confirmation response from the home health company for accepting the referral. -No documentation was provided. See NHA interview below. III. Staff interviews The NHA was interviewed on 3/11/24 at 9:28 a.m. He said the facility did not receive confirmation from the preferred home healthcare company that they were able to accept the referral for Resident #191. He said the facility discharged the resident without confirmation that home health services were arranged. The director of nursing (DON) was interviewed on 3/11/24 at 10:25 a.m. She said the discharge process was to receive a physician order to discharge, and the social services department opens up a discharge summary with IDT involvement. She said social services makes a plan that includes needs, goals, appointments, equipment, home healthcare or other ancillary needs. The DON said if there were not any home health companies that were available to take a referral, social services should inform the physician and the resident/responsible party. The DON said if the physician orders were not able to be followed for home healthcare services, they would reconsider the plan. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said communication between the home health company and the discharge planner was important to ensure a safe discharge. The DON said she would not have wanted Resident #191 discharged without home health services in place because Resident #191 at high risk of infection and hospitalization . The SSD, ANHA, and SSA were interviewed on 3/11/24 at 12:20 p.m. The SSD said the discharge process was to set up a care conference/IDT to see what was needed such as medical equipment, where going at discharge (i.e. home), home healthcare and other supportive services. The ANHA said a discharge date was then scheduled, and the physician would complete a discharge assessment. The SSA said if home health service were not available, she would offer outpatient therapy to the resident. The SSA said she was the case manager who arranged Resident #191's discharge home. She said Resident #191 was referred to a home health agency that the family preferred and that had cared for the resident in the past. The SSA said she sent the home health referral on Friday 2/2/24. She said the home health agency had accepted the referral. She said she did not have any documentation that the home health had received and accepted Resident #191's referral. The SSA said she found out on Monday 2/5/24 from the RR that the home health company did not accept the referral. The SSA said she did not follow up with the preferred home health company, nor offer to arrange alternate home health services. The referred home health company was contacted on 3/11/24 at 1:43 p.m. The home health referral coordinator (HHRC) said she received a fax referral from the facility for Resident #191 on 2/2/24. The HHRC said they did not receive a call from the facility to confirm or follow up. The HHRC said she called the facility to advise that the agency could not accept the referral because they did not have the staffing available. IV. Facility follow-up On 3/12/24 at 5:00 p.m., the NHA provided the following information via email: It revealed the INHA and SSA called the preferred home health provider following the survey on 3/12/24 to follow up on the home health care needs for Resident #191. The home health director of nursing (HHDON) responded in an email on 3/12/24 at 1:48 p.m. to the ANHA and revealed in pertinent part, Resident #191 was a client with (company name) home health for two years. In that time, she fired all clinicians and would constantly make complaints, which were unfounded. Since Resident #191 had declined all of our clinicians, we were unable to meet her needs to staff appropriately. Staffing was the reason why we could not take her back. Additionally, Resident #191 wrote a review about (company name) home health, rated very poorly, stating that we should, 'close our doors.' This was not a factor to decline the referral, only to give more details. When she would call about a complaint or issue, each time would end with her abruptly hanging up the phone until time passed and history would repeat itself. If you have any questions or would like more clarity, please let me know. - The documentation confirmed the preferred home health company declined the facility referral for Resident #191 due to staffing and the facility failed to follow up to ensure Resident #191 had a safe discharge and home health services at home per physician order and therapist recommendations.