STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1330 Sidney Ave Sterling, CO 80751

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 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** 50853 Based on record review and interview, the facility failed to develop and implement an effective discharge plan for one (#5) out of three residents reviewed for discharge planning out of 11 sample residents. Specifically, the facility failed to: -Ensure the discharge planning process was documented in Resident #5's electronic medical record (EMR); and, -Ensure Resident #5's representative was informed of the discharge planning process. Findings include: I. Facility policy and procedure The Transfer and Discharge policy, dated 2022, was provided by the nursing home administrator (NHA) on 9/17/24 at 3:36 p.m. It read in pertinent part, It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. Non-emergency transfers or discharges - initiated by the facility, return not anticipated. Document the reasons for the transfer in the medical record, and in the case of necessity for the resident's welfare and the resident's needs cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to meet the resident needs, and the services available at the receiving facility to meet the needs. Document any danger to health or safety of the resident or other individuals that failure to transfer or discharge would pose. II. Resident #5 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 #5, age 89, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, peripheral vascular disease (narrowing of blood vessels) and hypertension (high blood pressure). The 8/10/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to complete the brief interview for mental status (BIMS). She required minimal assistance with walking and required substantial to maximal assistance with dressing and personal hygiene. The assessment indicated Resident #5 had physically aggressive behaviors towards others and wandered, which had worsened since the last assessment and put the resident and others at risk for injury. The resident's discharge goal was not indicated on the assessment. III. Resident #5's representative interview Resident #5's representative was interviewed on 9/17/24 at 11:57 a.m. Resident #5's representative said she was not kept informed of what the facility was doing to assist Resident #5 in discharging to a secured environment. She said she was informed on 7/18/24 that her mom needed to move to a secured unit because of her behaviors and elopement risk. She said she was sad she had to move but agreed in order to keep her safe. She said the facility started to send out referrals but did not keep her informed throughout the process and was not informed that a local facility did an on-site visit recently. The representative said she requested a referral to a facility in Nebraska,since she thought the local facility had denied the referral, but it was not sent. She said the NHA told her it was not a secured facility so they could not send a referral there, however, Resident #5's representative said it was confirmed with that facility there was a secured unit. The representative said she selected specific facilities for referrals to be sent that were within a reasonable distance from her home so she could continue to visit Resident #5 frequently. IV. Record review The social services care plan, updated 5/28/24, indicated Resident #5 would remain in the facility and was receiving hospice services. -A review of the comprehensive care plan did not reveal the residents' need for discharge planning. The 7/18/24 multidisciplinary care conference summary documented the facility's concern for Resident #5's safety due to her wandering and exit seeking. There was discussion about moving Resident #5 to a secured unit for her safety and wellbeing. The resident's representative was not in favor of moving Resident #5 to another facility because she felt her needs could be met at this facility and did not want her moved far from here. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/18/24 hospice physician progress note documented Resident #5 was ambulatory within the facility and often walked around with her eyes closed. She did not tend to wander into other resident rooms, nor had she successfully eloped. She wears a wander guard, which had been a successful intervention to prevent elopement. -A review of the resident's EMR did not reveal documentation indicating the resident had attempted to elope from the facility in July 2024 or August 2024. The 7/19/24 physician note documented a care conference was held on 7/18/24 and the facility administration stated they could not adequately monitor Resident #5's wandering. The facility made a case to transfer the resident to a memory care unit but the resident's representative did not agree to this. The 7/22/24 social services progress note documented Resident #5's representative was notified that a referral packet was sent to the preferred long term care communities for Resident #5's placement in a secured community. -However, there was no documentation the representative agreed to the referrals and there was no documentation that the facility provided a facility initiated discharge notice. The 8/1/24 social service progress note documented Resident #5 was not accepted at two of the facilities where she was referred and the representative was notified. The 8/9/24 nursing progress note documented Resident #5's representative was in the facility. The resident's representative agreed to move Resident #5 to a secured memory care unit and referrals would be sent out the next Monday (8/12/24). The 8/12/24 nursing progress note documented a referral was sent to another facility and the representative was notified. The representative also requested another referral be sent. The 8/14/24 nursing progress note documented Resident #5 was accepted by another facility and the representative was notified. -However, there was no documentation in the EMR indicating why Resident #5 was not transferred to the accepting facility. -A review of the resident's EMR from 8/15/24 to 9/16/24 revealed there were no progress notes regarding discharge planning or communication with the representative regarding the status of discharge to another facility and no documentation of a facility initiated discharge notice. A 9/6/24 fax cover sheet was reviewed. It was handwritten, did not include a time stamp and showed the fax referral was sent to a facility in Nebraska on 9/6/24. V. Staff interviews (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service director (SSD) was interviewed on 9/17/24 at 9:40 a.m. The SSD said Resident #5 was exit seeking frequently and eloped a few times. The SSD said she discussed the concerns with the family. The SSD said the representative requested referrals be sent to specific facilities with secured units. The SSD said they had recently sent a referral to a facility in Nebraska, that the representative requested. She said one facility accepted Resident #5 but that facility changed their decision and declined. The SSD said another facility did an onsite visit last week. The SSD said she did not document everything in the resident's EMR. She said she did not save the referral packets that were sent but she may have emails. The SSD was interviewed again on 9/17/24 at 1:50 p.m. The SSD said she thought the director of nursing (DON) sent the referral to the facility in Nebraska but the DON told her she did not. The SSD said the referral was not sent. The NHA was interviewed on 9/17/24 at 2:30 p.m. The NHA said a referral to the a facility in Nebraska had not been sent because they did not have a secured unit. The NHA said she communicated this to Resident #5's representative. The regional clinical resource (RCR) was interviewed on 9/17/24 at 2:45 p.m. The RCR said the facility in Nebraska did have a secured unit and a referral was sent last week.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on interviews and record review the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (#1 and #5) of three residents out of 11 sample residents. Specifically, the facility failed to: -Ensure the as needed (PRN) pain medication had parameters for Resident #1; and, -Appropriately assess pain for Resident #5. Findings include: I. Professional reference The American Medical Directors Association (AMDA) The Society for Post-Acute and Long-Term Care Medicine Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. [NAME], MD (2021), was retrieved on 9/18/24 from www.paltc.org, read in pertinent part, When several options for administering analgesics are ordered for a patient, nursing staff need adequately detailed guidance concerning how and when to select a PRN medication from among the several options that have been ordered. II. Facility policy and procedure The Pain Management policy, dated 5/3/23, was provided by the regional clinical director (RCD) on 9/16/24 at 5:39 p.m. It read in pertinent part, Purpose: to accurately assess and achieve pain control. Pain evaluations will be documented on the Pain Evaluation in the electronic medical record and/or the Medication Administration Record as applicable, to include location, intensity rating, and response to pain management interventions. When a resident complains of pain, ask the resident to rate the level of pain using the Numerical Scale using a pain level of zero (none) to ten (severe). Cognitively impaired residents or residents unable to respond verbally may not be able to rate their pain using a numeric scale. Non-verbal indicators of pain include: increased agitation, crying, grimacing, holding the area where the pain is located, calling out, decreased appetite, and any other behaviors which are unusual for the resident. Cognitively impaired residents have pain evaluated using the PAINAD (Pain Assessment in Advanced Dementia) scale. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and passed away on 8/15/24. According to the September 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage in multiple body parts), osteoarthritis (degeneration of joint cartilage causing pain and stiffness), chronic pulmonary embolism (blood clots in arteries of the lung), atrial fibrillation (irregular heartbeat) and mild vascular dementia (cause by impaired blood supply to the brain). The 7/27/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS assessment documented Resident #1 was dependent on staff for transfers and used a wheelchair for mobility. B. Record review The comprehensive pain assessment, completed on 7/24/24, indicated Resident #1 had diabetic nerve pain and muscle pain that affected her mood. The assessment documented pain relief interventions for Resident #2 were routine pain medication and relaxation. The pain care plan, initiated on 5/30/24, indicated the resident had pain related to peripheral neuropathy, intervertebral disc degeneration and osteoarthritis. Interventions included administering medication per orders, evaluating the effectiveness of intervention, identifying, recording and treating existing conditions which increased pain, monitoring, recording and reporting non-verbal signs of pain, notifying the physician if interventions were unsuccessful and offering non-pharmacological interventions for pain prior to administering medication. According to the August 2024 CPO, Resident #1 had the following physician orders for pain management: -Gabapentin 600 milligrams (mg) one tablet every morning and at bedtime related to polyneuropathy, ordered on 7/17/24; -Acetaminophen extra strength 500 mg (Tylenol) one tablet every six hours as needed for pain level of one to ten out of 10, ordered on 6/10/24; -Morphine sulfate oral Solution 100 mg/5 milliliters (ml), 0.25 ml every two hours as needed for pain, ordered on 8/14/14; and, -Roxicodone intensol 20mg/ml concentrated solution. Give 0.5ml every four hours as needed for end of life pain, ordered on 8/13/24. -The physician's orders did not include pain parameters for morphine sulfate or Roxicodone indicating when to administer the Tylenol 500 mg versus the morphine sulfate or Roxicodone. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the August 2024 medication administration record (MAR), the acetaminophen and Roxicodone were not administered. The morphine was administered 21 times for pain levels between 0 and 6 out of 10. According to the August 2024 MAR (8/1/24 to 8/16/24), morphine sulfate was administered at the following times when there was no pain documented. -On 8/13/24 at 11:47 p.m. morphine sulfate 100 mg/5ml, 0.25 ml was administered. The nurse documented it was administered per family request and no indication of pain was noted. The nurse documented the resident's pain level was 0 out of 10 at the time of administration. -On 8/15/24 at 8:15 a.m. morphine sulfate 100mg/5ml, 0.25ml was administered. The nurse documented it was routine morphine per family request for resident comfort. The nurse documented the resident's pain level was 0 out of 10 at time of administration. -On 8/15/24 at 2:22 p.m. morphine sulfate 100mg/5ml, 0.25ml was administered. The nurse documented the morphine was routine for comfort care and the resident's pain level was 0 out of 10. -On 8/15/24 at 4:22 p.m. morphine sulfate 100mg/5ml, 0.25ml was administered. The nurse documented the morphine was routine for comfort care and the resident's pain level was 0 out of 10. III. Resident #5 A. Resident status Resident #5, age 89, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, peripheral vascular disease (narrowing of blood vessels), and hypertension (high blood pressure). The 8/10/24 MDS assessment revealed the resident was severely cognitively impaired and unable to complete the BIMS assessment. She required minimal assistance with walking, required substantial to maximal assistance with dressing and personal hygiene and was on hospice care. B. Record review The pain care plan, initiated on 8/10/24, indicated the resident had pain related to traumatic subdural hemorrhage, peripheral vascular disease, Alzheimer's disease, heart failure, and chronic kidney disease. Interventions included administering analgesia per physician orders, evaluating the effectiveness of pain intervention, notifying the physician if interventions were unsuccessful and offering relaxation, walking, routine pain management, and a quiet environment. According to the August 2024 CPO, Resident #5 had the following physician's orders for assessing the resident's pain: -Pain check every shift using the PAINAD scale (pain assessment in advanced dementia) every shift for monitoring, ordered on 6/10/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the medical record, the PAINAD was not utilized on a consistent basis for determining Resident #5's pain level. Nurses documented a numerical pain scale (0-10) was utilized 24 days out of the past 30 days (8/18/24 to 9/17/24.) C. Staff interviews The director of nursing (DON) was interviewed on 9/16/24 at 4:45 p.m. The DON said the facility utilized a numerical pain scale for pain assessments and the PAINAD for residents who were unable to communicate or if their cognition was impaired. She said if the physician's order indicated to use the PAINAD the nurses needed to follow that. The DON said Resident #5's pain should have been assessed using the PAINAD due to her cognitive impairment and the physician's order. She said the nurses were not following the physician order when they used the numerical pain scale. The DON said if a resident had more than one as needed pain medication ordered there should be pain level parameters or an indication for use for each medication. She said the nurses should follow the parameters to determine what pain medication to administer. The DON said the nurses should assess pain before administering an as needed pain medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for four (#1, #5, #6 and #8) of five residents reviewed for hospice services out of 11 sample residents. Specifically, the facility failed to: -Obtain a complete physician's order for hospice care for Resident #1 and Resident #8; -Ensure hospice agency notes were easily accessible to facility staff and have consistent documentation of hospice care visits and updates for Resident #5, Resident #6 and Resident #8; -Initiate a hospice care plan timely for Resident #6. Findings include: I. Facility policy and procedure The Hospice policy, dated 2/29/24, was provided by the regional clinical director (RCD) on 9/16/24 at 5:39 p. m. It read in pertinent part, When a facility resident elects to have hospice care, the facility staff communicates with the hospice agency to establish and agree upon a coordinated plan of care that is based upon an assessment of the resident's needs and living situation in the facility. Develop a plan of care that reflects the participation of the hospice agency and the facility, and the resident and family to the extent possible. Ensure that the plan of care identifies the care and services which the facility and hospice agency will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care. Hospice communication will be reviewed and added to the medical record. Provide revisions to the plan of care to reflect the resident's most current status. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and passed away on 8/15/24. According to the September 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage in multiple body parts), osteoarthritis (degeneration of joint cartilage causing pain and stiffness), chronic pulmonary embolism (blood clots in arteries of the lung), atrial fibrillation (irregular heartbeat) and mild vascular dementia (cause by impaired blood supply to the brain). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/27/24 minimum data set (MDS) assessment revealed the resident had revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS assessment documented Resident #1 was dependent on staff transfers and used a wheelchair for mobility. The MDS assessment did not indicate the resident was receiving hospice services. B. Record review The 8/16/24 nursing progress note documented the hospice nurse was called at 10:30 p.m. on 8/15/24 to notify her of the resident's passing. -A review of Resident #1's electronic medical record (EMR) did not include a physician's order for hospice care. III. Resident #5 A. Resident status Resident #5, age 89, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, peripheral vascular disease (narrowing of blood vessels), and hypertension (high blood pressure). The 8/10/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to complete the brief interview for mental status (BIMS). She required minimal assistance with walking and required substantial to maximal assistance with dressing and personal hygiene. The assessment indicated Resident #5 was receiving hospice services. B. Record review The hospice care plan, initiated on 8/8/23 and revised on 3/4/24, indicated Resident #5 was receiving hospice services since August 2023. A physician's order, dated 8/8/23, for hospice evaluate and treat for primary diagnosis of non traumatic subdural hemorrhage. A review of the hospice notes in the facility EMR revealed the last hospice notes uploaded into the facility EMR were dated 7/18/24. There was no documentation in the resident's EMR indicating Resident #5 had been discharged from hospice services. -However, the director of nursing (DON) indicated Resident #5 was discharged from hospice services on 8/16/24 (see interview below). IV. Resident #6 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included pulmonary fibrosis (scarring of lung tissue causing shortness of breath and fatigue), chronic respiratory failure with hypoxia (low oxygen level), cardiomegaly (enlarged heart), chronic kidney disease, anxiety disorder and hypertension (high blood pressure). The 8/10/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of five out of 15. She required partial to moderate assistance with personal hygiene and transfers and used a wheelchair for mobility. The assessment indicated Resident #6 was receiving hospice services. B. Record review The physician's order indicated Resident #6 was admitted to hospice care on 4/1/24 with a diagnosis of chronic kidney disease stage 3. The facility hospice care plan was initiated on 4/27/24. -The care plan was initiated 26 days after the resident was admitted to hospice services. -A review of the facility EMR did not reveal hospice progress notes from August 2024 or September 2024 in the EMR. V. Resident #8 A. Resident status Resident 81, age 80, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included multiple sclerosis (disease that affects the nervous system), Alzheimer's dementia and chronic pain. The 6/29/24 MDS assessment revealed Resident #8 had severe cognitive impairments with a BIMS score of three out of 15. He required total assistance from staff with personal hygiene, dressing, transfers and did not walk. He was independent with wheelchair mobility. The assessment did not indicate Resident #8 was receiving hospice services. B. Record review A hospice care plan for Resident #8 was initiated on 12/19/23. The care plan did not include specific interventions for Resident #8 or indicate what care hospice staff would be providing. According to Resident #8's physician's orders, his level of care was changed to hospice on 1/8/24. -However, the physician's order did not include a diagnosis for the need for hospice care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the resident's EMR did not reveal hospice progress notes from August 2024 or September 2024. VI. Interviews The DON was interviewed on 9/16/24 at 4:45 p.m. The DON said if a resident's family asked for hospice services, the facility contacted the provider to request a physician's order for a referral to hospice services. She said the physician's order was entered into the EMR and a referral was sent to the hospice agency. The DON said she was not sure how long it usually took for hospice to respond and do an assessment because she had only worked at the facility a couple of months. The DON said the referral for Resident #1 was a special situation, because she requested hospice to come out right away since the resident was declining. She said Resident #1 was admitted to hospice the same day of the referral. The DON said the steps she took to refer and admit Resident #1 to hospice should have been documented in the resident's EMR and she should have obtained a physician's order. The DON said hospice notes were usually sent to the facility within a week of their visits. She said sometimes the facility had to ask for them. The DON said when they received the notes, the medical records staff uploaded the notes into the EMR. She said it was important for these notes to be accessible to nursing staff so they were aware of any changes in the hospice plan of care. The DON said Resident #5 had been discharged from hospice care on 8/16/24 which was documented on the hospice discharge form. The DON said the discharge form should have been included in Resident #5's EMR. The DON said the floor nurses entered the care plans into the EMR. The DON said the care plan should be updated within 24 to 48 hours of a resident being admitted to hospice care. The DON said the care plan for Resident #6 was not initiated timely. She did not know why it was not completed since she was not working at the facility during this time. The assistant director of nursing for the hospice agency was interviewed on 9/16/24 at 3:53 p.m. She said that when a nursing home resident requested hospice services the nursing home was responsible for obtaining the physician's order for hospice care and creating the plan of care in the resident's EMR. She said the hospice agency faxed their progress notes weekly to the nursing home.