STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065273	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Post Acute	6270 W 38th Ave Wheat Ridge, CO 80033

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on interviews and record review, the facility failed to ensure residents were permitted to remain in the facility and not transfer or discharge for one (#1) of three residents reviewed for discharge planning out of eight sample residents. Specifically, the facility failed to provide Resident #1 with an appropriate discharge process. Findings include: I. Facility policy and procedure The Transfer or Discharge, Facility-Initiated policy, revised October 2022, was provided by the nursing home administrator (NHA) on 10/21/24 at 1:15 p.m. It read in pertinent part, If the facility does not permit a resident's return to the facility (initiates a discharge) based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Sufficient preparation and orientation for the resident prior to an immediate facility-oriented transfer or discharge includes explaining to the resident where he/she is going and why, and taking steps to minimize his/her anxiety or depression (working with the resident, representative, or family to ensure that the resident's belongings will be taken care of and transferred to the new location as needed/requested, and ensuring that staff recognize characteristic resident reactions identified during assessment and care planning). Documentation of Facility-Initiated Transfer or Discharge When a resident is transferred or discharged from the facility, the following information is documented in the medical record: -The basis for the transfer or discharge; and, (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include the specific resident needs that cannot be met and the facility's attempt to meet those needs. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge is documented in the resident's clinical record by the resident's attending physician. The Transfer and Discharge policy, dated 2024, was provided by the NHA on 10/21/24 at 2:59 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. Discharge Against Medical Advice (AMA): The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present. Notify Adult Protection Services, or other entities, as appropriate if self-neglect is suspected. Document accordingly. III. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included end stage renal disease, peripheral vascular disease, chronic viral hepatitis C, opioid abuse, dependence on renal dialysis, polyneuropathy (nerve damage) and hypertension (high blood pressure). The 5/10/24 quarterly minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He was independent with eating, oral hygiene, toileting, and showering. He used a front wheel walker to ambulate. He experienced frequent pain, and received scheduled pain medication. He did not reject care from staff. He did not wander. B. Family interview (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A family member was interviewed on 10/21/24 at 2:45 p.m. The family member said Resident #1 was homeless before he was admitted to the facility and he was again homeless after the facility discharged him AMA. The family member said no one from the facility called the family member about the discharge even though they were the legal representative for Resident #1 and were listed as the contact person for the resident. The family member said Resident #1 did not receive his medications from the facility when he was discharged and the family member did not know why. C. Record review The comprehensive care plan, initiated on 1/9/24 and revised on 5/5/24, revealed Resident #1 was to have his medication administered as ordered by the physician, had a diagnosis of hypertension and was at risk for chest pain and dizziness. Resident #1 was at high nutritional risk related to dialysis and wounds, fluid overload with swelling. The resident had a history of dialysis refusals due to not feeling well. Pertinent interventions included providing a diet, supplements and vitamins/minerals per physician order and the facility was to coordinate care with the dialysis center's dietitian. The 5/31/24 nursing elopement risk assessment tool revealed the resident was not cognitively impaired with poor decision making skills, did not wander, did not leave the facility without notifying staff and was not at risk for elopement. The July 2024 CPO revealed Resident #1 was to receive scheduled dialysis every Tuesday, Thursday, and Saturday. -However, according to the resident's care plan, he frequently refused dialysis due to not feeling well (see care plan above). A behavioral contract, signed by Resident #1 on 7/12/24, documented in pertinent part, Resident #1 must adhere to the following expectations to remain a resident at (facility name): -Communicate with the nursing department prior to going out on pass and, -Take enough medication for the scheduled number of days you will be out. I read and understand the above-listed behavioral expectations. I understand if I choose to leave, without my prescribed medications, and do not return to (facility name) at the agreed upon time, I will be considered out AMA and immediately discharged from the facility. A 7/21/24 nurse progress note revealed, Resident #1 left (the facility) for an overnight pass with his medications. Resident #1 was expected to return on Monday 7/22/24 by 5:00 p.m. -However, according to the NHA, Resident #1 was not expected to return to the facility until 7/23/24 (see NHA interview below). The 7/21/24, 7/22/24 and 7/23/24 nursing progress notes documented Resident #1 was out of the facility on pass. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note dated 7/23/24 at 10:38 a.m. documented Resident #1 did not show up for his dialysis appointment. -However, according to the resident's care plan, he frequently refused dialysis due to not feeling well (see care plan above). An interdisciplinary team (IDT) progress noted, dated 7/23/24 at 3:53 p.m., revealed Resident #1 went out on pass and said he would return by 7/23/24 at 5:00 p.m. The facility attempted to reach him by phone and a message was left reminding him of the agreement he signed regarding if he did not return to the facility at an agreed upon time he would be discharged per the agreement. A nurse progress note, dated 7/23/24 at 6:06 p.m., documented Resident #1 would be back from being out on pass that evening at 5:00 p.m. Several phone calls were made to the resident's voicemail with no return call. As per facility contract, if he had not returned as agreed upon, he would be considered an AMA discharge. Resident #1 did not go to his dialysis appointment today (7/23/24) which he needed three times per week. The NHA informed (via voicemail) Resident #1 of his choices and the outcome. A physician's assistant progress note dated 7/25/24 (two days after the discharge) documented Resident #1 was doing overall well and tolerating his dialysis well. He went out on pass on 7/21/2024, did not return as he agreed to on 7/23/24 and was then discharged per policy. The note documented to refer to the nursing notes for attempts to contact the patient/family. -There was no documentation in Resident #1's electronic medical record (EMR) which revealed the resident's needs that could not be met by the facility or the attempts made by the facility to meet the resident's needs. IV. Staff interviews The NHA was interviewed on 10/21/24 at 2:20 p.m. The NHA said Resident #1 sometimes left the facility and did not return when he said he would. The NHA said Resident #1 signed a behavioral contract on 7/12/24 which read if Resident #1 did not return when he said he was going to return to the facility, the facility would discharge him AMA (see record review above). The NHA said she thought Resident #1 agreed to return in two days on 7/23/24, not in one day (on 7/22/24) as the nurse documented. The NHA said he did sign out of the facility and take one day of medications with him. The NHA said when she reached Resident #1 at night (on 7/23/24) via telephone the NHA thought he was safe because he told her he was sleeping on someone's couch. The NHA said she did not document that information. The NHA said she did not document anything about Resident #1's medications. The NHA said she thought she finally spoke to Resident #1 at 8:00 p.m. that night, however, she said the only documentation of Resident #1 being told he was discharged AMA was on 7/23/24 at 6:06 p.m. The NHA said she told Resident #1 over the phone he had signed a contract and because he did not keep it, he was declared AMA. The NHA said, had Resident #1 returned at 5:00 p.m like he said he would, she would have let him continue to live at the facility. The NHA said Resident #1 asked how he would get his belongings. The NHA said she told him she would box up his belongings and his bike for someone to come and get. The NHA said about a month later, someone did come in to get his belongings but she did not recall who the person was. (continued on next page)

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