

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Cambridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1685 Eaton St Lakewood, CO 80214	

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)
<p>F 0622</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950</p> <p>Based on record review and interviews, the facility failed to ensure a facility-initiated discharge procedure for non-payment was followed for one (#140) of three residents reviewed for discharge out of 34 sample residents.</p> <p>Resident #140, who had a diagnosis of urinary tract infection, atrial fibrillation (abnormal heart rhythm), type II diabetes mellitus, history of falling, depression and anxiety disorder, was admitted to the facility on [DATE] and discharged on [DATE]. The facility failed to provide preparations for a safe and orderly facility-initiated discharge for non payment. The resident chose not to transition to long term care (LTC) insurance. Resident #140 was found down on the floor of his motel room three days after the facility discharged him.</p> <p>The facility failed to provide the resident with a 30 day discharge notice and failed to notify the ombudsman of the discharge. Cross-reference F623 failure to notify the ombudsman so that protection, support, assistance and representation could have been provided to the resident.</p> <p>The facility failed to provide/refer home health services to the resident to continue his work with physical therapy (PT), occupational therapy (OT) and nursing care to provide wound care treatment for wounds to his feet and toes.</p> <p>The facility failed to provide and document resident education for wound care to his feet and toes and failed to provide and document the issuance of wound care supplies.</p> <p>Due to the facility's failure, the resident was found down on the floor of his motel room for three days by the driver hired to take the resident from the facility to the motel. He had gone back to check on the resident three days later out of concern for the resident's ability to care for himself. The resident was admitted to the hospital via emergency medical services (EMS) on 3/11/24 and was there as of 4/1/24 due to the lack of capacity to make medical or discharge decisions.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>(continued on next page)</p>

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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<p>F 0622</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Discharge Planning policy and procedure, dated 2/29/24, was provided by regional clinical resource (RCR) on 4/1/24 at 3:47 p.m. It read in pertinent part, In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or is determined be unsafe, the interdisciplinary team will treat this situation similarly to refusal of care:</p> <p>Discuss with the resident, (and/or their representative, if applicable) and document the benefits and/or risks, review alternative options, and document refusals of other options that could meet the resident's needs.</p> <p>If discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why.</p> <p>An active individualized discharge plan will address, at a minimum:</p> <ul style="list-style-type: none"> -Discharge destination, -Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. -Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. <p>II. Resident status</p> <p>Resident #140, age 80, was admitted on [DATE] and discharged on [DATE] to a motel. According to the March 2024 computerized physician orders (CPO), diagnoses included urinary tract infection, atrial fibrillation (abnormal heart rhythm), type II diabetes mellitus, history of falling, depression and anxiety disorder.</p> <p>The 1/15/24 admission 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. He was dependent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. He was able to walk 10 feet once standing with set up help. The resident used a manual wheelchair.</p> <p>The 3/8/24 discharge MDS assessment revealed a BIMS score of 14 out of 15. He was independent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. Walking 10 feet was not attempted due to medical conditions or safety concerns. He was independent with a manual wheelchair. Active discharge planning was already occurring for the resident to return to the community. No referral had been made to the local contact agency and the reason was referral not wanted.</p> <p>-However, the discharge MDS assessment of the resident's functional abilities differed from the physical therapy (PT) and occupational therapy (OT) discharge assessments (see record review below).</p> <p>III. Hospital representative interview</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The hospital clinical social worker (HCSW) was interviewed on 4/1/24 at 12:07 p.m. She said the resident was still in the hospital and did not have the capacity to make medical/discharge decisions at this time nor had he throughout his entire admission. The HCSW said it was only on 3/26/24 that the providers felt he had capacity to designate a decision maker and his medical power of attorney (MDPOA) was now the driver who found the resident down in the motel.</p> <p>IV. Record review</p> <p>-Review of the comprehensive care plan revealed the resident did not have a care plan related to his discharge plan.</p> <p>The physician order dated 2/21/24 revealed, Wound care right lateral foot: cleanse with wound cleanser, pat dry, apply medihoney to wound bed cover with bordered gauze.</p> <p>The physician order dated 2/29/24 revealed, Wound care: right proximal heel: cleanse with sound cleanser, air dry, skin prep peri wound, medihoney gel to wound bed, cover with foam island dressing.</p> <p>The physician order dated 2/29/24 revealed, Wound care: right 2nd toe: paint with betadine and leave open to air.</p> <p>The physician order dated 3/6/24 revealed, Wound care: left 2nd toe: cleanse with wound cleaner, pat dry, apply medihoney to wound bed and cover with bordered gauze.</p> <p>The physician order dated 3/7/24 revealed, Wound care: right heel: cleanse with wound cleanser, air dry, skin prep peri wound, xeroform to wound bed and cover with bordered gauze.</p> <p>The physician order dated 3/8/24 revealed, Okay to discharge resident to the community on 2/8/24, revised 3/8/24.</p> <p>-However, there was no documentation that wound care supplies were issued to the resident at discharge with instructions on how to perform wound care with a return demonstration.</p> <p>-Home health nursing for wound care was not ordered for the resident.</p> <p>-Review of the PT/OT notes revealed there was no home evaluation completed prior to discharge.</p> <p>Review of the 3/6/24 OT discharge summary, with dates of service from 1/14/24 to 3/6/24 revealed the discharge reason was per physician or case manager.</p> <p>The short-term goals of safely completing toileting with moderate assistance with use of durable medical equipment (DME) as needed was not met, maximum assistance has continued to rely on certified nurse aide (CNA) assistance for brief changes. Resident was able to complete lower body dressing with moderate assistance with use of assistive equipment and compensatory strategies as needed. Resident was able to safely complete bathing with minimum assistance with use of DME and compensatory strategies as needed.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Goal of the resident self-propelling wheelchair independently in order to access items needed for participation in ADLs and other functional tasks was not met, patient requires assistance to manage wheelchair over any kind of uneven surface, in tight spaces, and around obstacles.</p> <p>The long term goal of completing all ADL related transfers with modified independence with least restrictive assistive device (AD) in order to reduce risk of falls was not met, resident required contact-guard (CGA) to minimum assistance.</p> <p>Discharge location was other homeless shelter. Assistance/support to be provided was none. Functional skills assessment at discharge was, eating set-up or clean-up assistance; oral hygiene supervision or touching assistance; toileting hygiene dependent; shower/bath partial/moderate assistance; upper body dressing partial/moderate assistance; lower body dressing substantial/maximal assistance; putting on/off footwear substantial/maximal assistance.</p> <p>Discharge recommendations: OT recommended that patient convert to LTC, but despite education from IDT (interdisciplinary team) patient has consistently refused this and will now be discharging to a homeless shelter. OT recommends HH (home health) as available.</p> <p>-However, the resident was discharged without a home health referral.</p> <p>Review of the 3/7/24 PT discharge summary, with dates of service from 1/11/24 to 3/7/24 revealed the discharge reason was exhausted benefits, patient declines treatment.</p> <p>The short-term goals of five times sit to stand was not met, patient is unable to complete without physical assistance.</p> <p>The short-term goal of patient will decrease risk for falls as evidenced by a decrease (improved) score on the TUG (timed up and go) to two minutes was not met, patient is unable to participate.</p> <p>The long-term goal of patient will ambulate 200 feet with rollator with modified independence was not met, ambulates 20 feet with two wheel walker and contact guard to minimum assistance.</p> <p>Discharge location was other (hotel). Assistance/support to be provided was none.</p> <p>Functional skills assessment at discharge, bed mobility Independent; transfers sit to stand partial to moderate assistance; chair/bed to chair transfer partial to moderate assistance; toilet transfer partial to moderate assistance; ambulation 10 feet with partial to moderate assistance. Resident uses a wheelchair. Picking up objects partial to moderate assistance. Progress and response to treatment, patient demonstrates minimal progress as patient continues to require assistance for activities of daily living (ADLs) and functional skills.</p> <p>Discharge recommendations: patient not deemed safe to discharge from facility without assistance.</p> <p>-However, the facility discharged the resident without assistance.</p> <p>-Review of all the progress notes revealed there were no IDT or care conference notes related to discharge planning.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950</p> <p>Based on record review and staff interviews, the facility failed to ensure one (#140) of three residents and/or their responsible person and the ombudsman were provided a written discharge notice to include the reasons for the move in a language and manner they would understand out of 34 sample residents.</p> <p>Specifically, the facility failed to provide Resident #140 an appropriate written notice of discharge from the facility that included:</p> <ul style="list-style-type: none"> -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident was transferred or discharged ; -A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; -Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request; and, -The name, address (mailing and email) and telephone number of the Office of the State. <p>In addition, the facility failed to provide notice to the ombudsman of Resident #140's discharge.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Admission Agreement policy, dated 2018, was provided by the regional clinical resource (RCR) on 3/31/24 at 5:54 p.m. It read in pertinent part, Nonpayment of invoices or failure to arrange for payments from a payment source will result in your discharge. You will receive a written notice of your impending discharge at least thirty (30) days before the effective date of such discharge.</p> <p>As a resident of our facility, you may not be transferred or discharged from our facility against your wishes except for the following reasons: You fail to pay for your stay at our facility after reasonable and appropriate notice, including your failure to submit the necessary paperwork for third-party payment after the third-party payor (including Medicare and Medicaid) denies the claim and you refuse to pay for your stay.</p> <p>We will provide you with written notification thirty (30) days in advance of the planned (non-emergency) transfer or discharge. The written notice also will contain a statement regarding your right to appeal the decision and any other information required by applicable Federal or state law.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse note dated 3/8/24 revealed in pertinent, Taxi came to pick the resident up and take him to (brand name) motel in (name or city). Left at 1500 (3:00 p.m.) and left with all of his belongings, discharge packet, medication and times. Skin is intact but his both feet that had frost bites, and his dressings were changed before he left. Denied any pain when asked. Resident signed the discharge packet before he left.</p> <p>Hospital emergency department and admission notes, dated 3/11/24, revealed in pertinent part,</p> <p>Patient presented after being found down. He states that he was non ambulatory but was told he would have to leave his post-acute facility because of insurance. States that the facility paid for three days at a motel and discharged him.</p> <p>The hospital progress note dated 3/13/24, Patient's prior provider reported a history of cognitive impairment and lack of insight however patient was discharged to motel without any support.</p> <p>IV. Staff interviews</p> <p>The social services director (SSD) was interviewed on 3/28/24 at 8:47 a.m. The SSD said he did not contact the ombudsman or issue a facility discharge notice.</p> <p>The regional clinical resource (RCR) was interviewed on 4/1/24 at 2:55 p.m. The RCR said the facility did not issue a facility initiated discharge notice to the resident or notify the ombudsman.</p>