STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065322	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Temple Healthcare Center	3401 S Lafayette St Englewood, CO 80113

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** 51711 Based on observations, record review and interviews, the facility failed to develop and implement an effective discharge plan for two (#362 and #466) of two residents reviewed for discharge planning out of 51 sample residents. Specifically, the facility failed to: -Ensure Resident #362 and #466 and/or their responsible party were apprised of their progress and discharge planning; and, -Ensure the discharge planning process was documented in the residents' electronic medical records (EMR). Findings include: I. Facility policy and procedure The Discharge Planning policy and procedure, revised February 2020, was provided by the nursing home administrator (NHA) on 12/10/24 at 9:00 p.m. It read in pertinent part, It is the policy of this facility that discharge planning and evaluation will be provided by the social services staff for each resident. The discharge planning process focuses on the resident's discharge goals, the preparation of the resident to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The social services staff will ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. The social services staff member assigned to the resident regularly evaluates and re-evaluates the resident to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. 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. II. Resident #466 A. Resident status (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	Resident #466, age 77, was admitted on [DATE]. According to November 2024 computerized physician orders (CPO), diagnoses included encounters for cerebral vascular accident (CVA: medical condition that occurs when blood flow to the brain is suddenly interrupted, which can lead to brain cell death and neurological damage), muscle weakness, unsteadiness on feet and history of falls. The 11/15/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 14 out of 15. He required moderate to maximum assistance with all activities of daily living (ADL). The assessment indicated the resident's overall goal was to be discharged back into the community and active discharge planning was occurring. B. Resident interview and observation Resident #466 was interviewed on 12/5/24 at 9:37 a.m. Resident #466 said he was frustrated he had not been kept informed of his progress and did not know what specifically he needed to do to discharge home from the facility. He said nobody was in charge of the discharge process and nobody would take responsibility. He said he had requested a criteria for the goals he needed to meet with therapy or facility goals related to his care in order to facilitate his discharge from the facility more quickly. Resident #466 said he still had not been provided the discharge criteria he requested. Resident #466 said it was human nature for people to pass the buck but it was the responsibility of the facility staff to make the decisions and provide him with the information. He said he was not the person to decide if he could discharge home and he wanted someone to stand up and say they were responsible for providing the discharge information to him. He said he wanted someone to have a discussion with him and tell him what they needed from him for him to be able to discharge. C. Record review The discharge care plan, initiated 11/13/24, documented the goal for Resident #466 was to be able to verbalize and communicate the services required to meet his needs before discharge. The interventions included establishing a pre-discharge plan with the resident and family/caregivers, evaluating the resident's progress, revising the discharge plan as needed, recording the resident's abilities and strengths and determining resident's gaps in abilities with the resident and family/caregivers to determine if it would affect the resident's discharge. The 11/13/24 skilled weekly progress note, which included the NHA, social services, therapy, the MDS coordinator and nursing, documented Resident #466 had an anticipated maximum potential to be achieved in three to four weeks. The resident's plan was to discharge home with his spouse and home health services. The 12/4/24 physician medicine and rehabilitation follow up progress note documented the resident was anxious to get an update regarding his discharge timing. The physician documented he would coordinate with the discharge team. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician further documented in the 12/4/24 progress note that Resident #466's anticipated maximum potential from his skilled stay would be achieved in one to two weeks and he would discharge home with his spouse and home health services. -A review of the resident's electronic medical record (EMR) did not reveal documentation the facility had met with Resident #466 and/or the resident's representative to discuss the resident's progress toward discharge or his progress status. -The EMR did not include documentation of an active discharge plan involving Resident #466 and his representative from the time of the resident's admission to the facility to his current status. D. Staff interviews Rehabilitation transitions director (RTD) #1, who was part of the facility's social services team, was interviewed on 12/5/24 at 4:59 p.m. RTD #1 said when residents were admitted to the facility, she met with the residents and the residents' representatives, either in person or via telephone, to sign admission agreements. She said the initial care plan was created within 48-hours of the resident's admission to the facility. The RTD said the initial goal of all residents was to return home with their family or to their prior living arrangement. She said it was social services responsibility to develop and revise the discharge care plan throughout the resident's stay at the facility, in conjunction with their progress with rehabilitation services. RTD #1 said the facility staff held a meeting amongst themselves on 12/4/24 to discuss Resident #466's progress. She said it was discussed that Resident #466 had met his maximum potential for rehabilitation and the plan was to discharge the resident home early next week (week of 12/9/24). She said she had advised Resident #466 on the afternoon of 12/5/24 about the upcoming discharge, but she said she had not yet communicated with the resident's representative. RTD #1 said she had not met with Resident #466 and/or the resident's representative to discuss the discharge plan or provided them with the Notice of Medicare Non-Coverage (NOMNC) to inform them the resident's Medicare skilled services benefits were ending. She said she would provide them with the information and the NOMNC on 12/6/24 for a planned discharge on 12/9/24. RTD #1 said following the meeting with Resident #466 and the resident's representative to create the initial plan of care, she did not document discharge planning within the resident's EMR. She said attempts to meet with residents and the residents' representatives occurred as often as possible but she said it was not documented in the resident's EMR. 51163 III. Resident #362 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 #362, age 85, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included spondylosis without myelopathy or radiculopathy (condition that occurs when the spine degenerates without injuring the spinal cord or pinching a nerve) of the cervical region (neck), history of falling, cognitive communication deficit and dementia. The 11/25/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She required substantial to maximal assistance or was dependent with the majority of her ADLs. The assessment indicated the resident's overall goal was to be discharged back into the community or to go back home and active discharge planning was occurring. B. Resident representative interview Resident #362's representative was interviewed on 12/5/24 at 11:02 a.m. The representative said he had not been included in the care planning process for Resident #362. He said he had not received any information and was not sure when the resident would discharge home. He said he would like to receive some information in order to plan for the resident's discharge. C. Record review The discharge care plan, revised 12/3/24, documented Resident #362 planned to discharge home with her spouse and home health care services. Interventions included coordinating with family to create and maintain personal shadow box; encouraging family and the resident to be involved with facility events and plan of care, establishing a pre-discharge plan with family and the resident, evaluating the resident's progress and revising the discharge plan as needed, evaluating and discussing the discharge plan with the family and the resident, identifying, discussing and addressing limitations, risks, benefits and needs for maximum independence and evaluating and recording the resident's abilities and strengths with the family to determine gaps in abilities which will affect the resident's discharge. The 11/22/24 progress note documented the initial care plan was verbally reviewed with social services and the resident's representative. It indicated the resident's goal was to return home with her spouse. The 12/9/24 progress note documented a NOMNC was issued to Resident #362 and the resident's representative. It indicated the resident's representative decided, that day (12/9/24), that the resident was to remain at the facility for long-term care. -However, the resident's EMR did not reveal any documentation of interdisciplinary (IDT) meetings regarding Resident #362's discharge plan or the progress that the resident was making towards discharge. -A review of Resident #362's EMR did not reveal documentation of an active discharge planning process. The facility did not document any meetings with the resident's representative to discuss Resident #362's progress toward discharge, a potential change to the discharge plan or to provide the resident's representative with any potential services for care at home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff Interviews RTD #1 was interviewed on 12/10/24 at 2:30 p.m. RTD #1 said within 72-hours of a resident's admission to the facility, the resident's discharge plan was reviewed with the interdisciplinary team, the family and the resident. She said all interactions and discussions regarding a resident's discharge plan should be documented in the resident's EMR. RTD #1 said up until she had called Resident #362's representative on 12/9/24, the resident's discharge plan was to return home with her spouse. RTD #1 was interviewed again on 12/10/24 at 5:30 p.m. She said she received a call from Resident #362's representative on 12/5/24, during the survey process. She said the resident's representative said he might want the resident to stay at the facility for long-term care. She said she had not had discussions related to the resident's discharge with the representative prior to the phone call on 12/5/24. The NHA was interviewed on 12/10/24 at 7:01 p.m. The NHA said all of the residents' discharge planning went through RTD #1's department. He said active discharge planning started at the residents' admission to the facility. He said the resident and the residents' families should be involved in the discharge planning process and it should be documented in the EMR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to ensure one (#113) of one resident received treatment and care in accordance with professional standards of practice out of 51 sample residents. Specifically, the facility failed to provide timely treatment when Resident #113 was experiencing several episodes of diarrhea. Findings include: I. Facility policy and procedure The Change of Condition Reporting policy and procedure, revised October 2020, was received from the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It read in pertinent part, It is the policy of this facility that all changes in resident condition will be communicated to the physician. All symptoms and unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. The nurse will document the resident change of condition and response in nursing progress notes, on the 24-hour report or dashboard and update the resident care clan, as indicated in the clinical meeting. The licensed nurse responsible for the resident will continue assessment and documentation every shift for at least seventy-two (72) hours or until condition has stabled. II. Resident #113 A. Resident status Resident #113, age 71, was admitted on [DATE]. According to the November 2024 computerized physicians orders (CPO), diagnoses included cognitive communication deficits, muscle weakness, sepsis and syncope (a loss of consciousness for a short period of time, or fainting). The 11/18/24 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. The MDS assessment revealed the resident was frequently incontinent of both bowel and bladder. B. Resident representative interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #113's representative was interviewed on 12/10/24 at 2:00 p.m. The representative said Resident #113 was immobile and had severe diarrhea when he first admitted to the facility. The representative said Resident #113 requested an anti-diarrheal medication on 10/31/24, 11/1/24 and 11/2/24. The representative said she received a phone call on 11/2/24 from Resident #113 and he told her he was having diarrhea. Resident #113's representative said she called the facility and requested an anti-diarrheal medication for Resident #113. She said the facility ordered the medication for the resident the next day (11/3/24). C. Record review The October 2024 and November 2024 bowel movement and bowel continence records for Resident #113 revealed the following: -On 10/31/24 at 9:56 p.m. the resident had a large loose stool; -On 11/1/24 at 8:58 a.m. the resident had a loose stool at 8:58 a.m.; -On 11/1/24 at 3:17 p.m. the resident had a formed stool; -On 11/2/24 at 5:28 a.m. the resident had a large loose stool; -On 11/2/24 at 9:37 a.m. the resident had a loose stool; -On 11/2/24 at 4:16 p.m. the resident had a formed stool; -On 11/3/24 at 5:31 a.m. the resident had a large loose stool; -On 11/3/24 at 9:19 a.m. the resident had a large loose stool; and, -On 11/3/24 at 4:53 p.m. the resident had a formed stool. A daily skilled nursing note, dated 11/1/24 at 8:42 a.m., revealed no active gastrointestinal symptoms were observed for Resident #113. -However, Resident #113 had an episode of a large loose stool the night before (10/31/24). A nursing progress note, dated 11/3/24 at 12:17 p.m., revealed Resident #113 experienced diarrhea and nausea. The nurse called the physician and received orders for an anti-nausea medication and Imodium (anti-diarrheal medication). -However, Resident #113 had six episodes of large loose stools between 10/31/24 and 11/3/24 before a physician's order for an antidiarrheal medication was obtained (see above). A grievance report, dated 11/3/24, revealed Resident #113's representative expressed her concern about the fact that Resident #113 had been having diarrhea since 11/1/24 with no medications administered. Interventions listed for this report included speaking to the floor nurse, who spoke with the physician and received an order for Imodium. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #113's November 2024 CPO revealed a physician's order for Imodium 2 milligram (mg) tablets. Give one tablet by mouth every six hours as needed for diarrhea for five days, ordered 11/3/24 at 12:19 p.m. The November 2024 medication administration record (MAR) revealed Resident #113 received two doses of Imodium on 11/3/24. The first dose was at 3:04 p.m. and was marked as being effective. The second dose was given at 8:18 p.m. and was marked as unknown for its efficacy. D. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 12/9/24 at 6:14 p.m. CNA #10 said if a resident had diarrhea, she would alert the nurse. Licensed practical nurse (LPN) #5 was interviewed on 12/10/24 at 6:00 p.m. LPN #5 said if a resident had one bout of diarrhea, he would look at the bowel movement records and the resident and see if it was something concerning or maybe just a result of something the resident ate. LPN #5 said if the bowel movement was concerning he would alert the physician. LPN #5 said if a resident was having multiple bouts of diarrhea he would fill out a change of condition form in the resident's electronic medical record (EMR), alert the physician and follow the orders the physician gave. The director of nursing (DON) and the CNR were interviewed together on 12/10/24 at 5:12 p.m. The DON said when a resident had diarrhea, they were put on monitoring for 72-hours and the provider was notified. The DON said if the resident had any stool softeners in their orders, the stool softener would be put on hold. The DON said this procedure was done for even one bout of diarrhea. The DON said the provider needed to be notified if a resident had diarrhea, as the diarrhea could be occurring for a number of reasons, including medication side effects or a bacterial infection. The CNR said if Resident #113 was having multiple bouts of loose stools, the provider should have been notified timely. The CNR said the provider would take into account any medications the resident was on that could cause diarrhea as a side effect. The DON and the CNR reviewed Resident #113's record but were unable to locate any progress notes related to Resident #113's diarrhea prior to the note which documented the physician was notified and prescribed Imodium for the resident on 11/3/24.