

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1685 S 21st St Colorado Springs, CO 80904	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31229</p> <p>Based on record review and interviews, the facility failed to provide a written discharge notice to to the resident or their representative and the State Long-Term Care Ombudsman at least 30 days before the resident's discharge for one (#1) of three residents reviewed for transfer/discharge out of three sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Provide Resident #1 and her representative an appropriate written notice of discharge from the facility that included:</li> <li>-The reason for transfer or discharge;</li> <li>-The effective date of transfer or discharge;</li> <li>-The location to which the resident was transferred or discharged ;</li> <li>-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;</li> <li>-Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request; and,</li> <li>-The name, address (mailing and email) and telephone number of the Office of the State; and,</li> <li>-Provide written notice to the ombudsman of Resident #1's facility-initiated discharge.</li> </ul> <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Transfer or Discharge, Facility-Initiated policy and procedure, undated, was provided by the assistant director of nursing (ADON) on 1/30/25 at 3:20 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation and documentation, as specified in this policy.</p> <p>Facility-Initiated transfer or discharge means a transfer or discharge which the resident objects to, and/or is not in alignment with the resident's stated goals for care and preference.</p> <p>If the facility does not permit a resident's return to the facility based on inability to meet the resident's needs, the facility will notify the resident and his or her representative in writing of the discharge, including notification of appeal rights.</p> <p>The facility will send a copy of the discharge notice to a representative of the Office of the State LTC (long term care) Ombudsman.</p> <p>If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.</p> <p>The resident and his or her representative are given a thirty (30)-day advance notice of an impending transfer or discharge from the facility. The resident and representative are notified in writing of the following information:</p> <ul style="list-style-type: none"> <li>-The specific reason for the transfer or discharge, including the basis;</li> <li>-The effective date of the transfer or discharge;</li> <li>-The specific location to which the resident is being transferred or discharged ; and,</li> <li>-An explanation of the resident's rights to appeal the transfer or discharge to the state, including the name, address, email and telephone number of the entity which receives such appeal hearing requests.</li> </ul> <p>A copy of the notice is sent to the office of the state long-term care ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1, age greater than 65, was initially admitted on [DATE] and readmitted after hospitalizations on 8/15/24, 11/20/24 and 12/24/24. According to the January 2025 computerized physician orders (CPO), diagnoses included alcoholic cirrhosis of the liver, type 2 diabetes mellitus with other diabetic kidney complication, acquired absence of left leg above the knee, dependence on wheelchair, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, alcohol dependence, in remission, anxiety disorder, hepatic encephalopathy, Parkinsonism and cognitive communication deficit.</p> <p>The 11/26/24 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. She required supervision for most functional activities of daily living (ADL).</p> <p>The assessment documented the resident had no behavioral symptoms, including physical, verbal, or other and there was no rejection of care.</p> <p>She was administered insulin injections, antianxiety, antidepressant, antibiotic, diuretic and hypoglycemic medications daily.</p> <p>III. Record review</p> <p>-Review of Resident #1's electronic medical record (EMR) revealed the facility failed to provide a written notice for the facility-initiated discharge to Resident #1, to include her appeal rights, and failed to send a written copy of the notice to a representative of the office of the state long term care ombudsman.</p> <p>-The facility failed to provide a reason for the sudden discharge.</p> <p>Cross-reference F626 for failure to permit a resident to return to the facility following a discharge.</p> <p>On 1/30/25 at 4:50 p.m., the ADON provided a statement that Resident #1's representative was notified verbally by the director of nursing (DON) and the social services director (SSD) of the facility's decision to not readmit the resident after her hospitalization .</p> <p>-However, the facility failed to provide documentation of the discharge notice and notification to the ombudsman (see interviews below).</p> <p>Review of Resident #1's EMR revealed the following progress notes:</p> <p>The 1/10/25 nurses note revealed Resident #1 refused to take her medications because her stomach was upset and she was afraid she would throw up. The note documented that due to the management's previous instruction, the nurse proceeded to call the resident's representative, who came to the facility and the resident took her medications.</p> <p>On 1/14/25 the ADON documented that on Friday 1/10/25 at 3:45 p.m., Resident #1's representative requested the resident be sent to a hospital, because she said the resident was lethargic. The ADON further documented Resident #1 appeared to be at her baseline per nursing assessment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 1/14/25 interdisciplinary team (IDT) note documented the IDT team discussed the resident's status at the hospital. It was determined with the regional nurse that the facility was not able to accept her back due to not being able to meet her needs, as the resident would not allow interventions to be put in place to accommodate her safety to prevent abuse physically and verbally. PACE (program of all-inclusive care for the elderly), the ombudsman, the resident's representative and the hospital caseworker were involved in the conversation.</p> <p>Review of Resident #1's EMR on 1/29/25, revealed the following:</p> <ul style="list-style-type: none"> <li>-There was no discharge summary or assessment documentation;</li> <li>-There was no documentation of appropriate orientation and preparation of the resident prior to transfer or discharge; and,</li> <li>-There was no written discharge notice documentation.</li> </ul> <p>IV. Interviews</p> <p>A frequent visitor (FV) was interviewed on 1/30/25 at 2:34 p.m. The FV said she did not receive a facility-initiated discharge letter from the facility when Resident #1 was discharged . She said Resident #1 and her representative did not receive the discharge letter and were not aware of the appeal rights. The FV said the resident's representative told her that she would like to appeal the discharge, however she did not know how to appeal.</p> <p>The DON and the ADON were interviewed together on 1/30/25 at 3:10 p.m. The ADON said the facility did not send a written facility-initiated discharge notice to Resident #1 and her representative, or to the ombudsman office.</p> <p>The DON said the IDT made the decision of not accepting Resident #1 back due to the resident refusing to take her medications which had led to her mental status changes and hospitalization s.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	
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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31229</p> <p>Based on record review and interviews, the facility failed to allow resident to return to the facility after transfer to a hospital for one (#1) of three residents reviewed for facility-initiated transfers out of three sample residents.</p> <p>Specifically the facility failed to permit Resident #1 to return after a hospitalization on [DATE].</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Transfer or Discharge, Facility-Initiated policy and procedure, undated, was provided by the assistant director of nursing (ADON) on 1/30/25 at 3:20 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.</p> <p>Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to, and/or is not in alignment with the resident's stated goals for care and preference.</p> <p>Residents who are sent emergently to an acute care setting are considered facility-initiated transfers, not discharges, because the resident's return is generally expected.</p> <p>Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility.</p> <p>A resident's declination of treatment is not grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. The facility will document that the resident or, if applicable, resident representative, received information regarding the risks or refusal of treatment and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was initially admitted on [DATE], and readmitted after hospitalization s on 8/15/24, 11/20/24 and 12/24/24 and discharged to the hospital on 1/10/25. According to the January 2025 computerized physician orders (CPO), diagnoses included alcoholic cirrhosis of the liver, type 2 diabetes mellitus with other diabetic kidney complication, acquired absence of left leg above the knee, dependence on wheelchair, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, alcohol dependence, in remission, anxiety disorder, hepatic encephalopathy, Parkinsonism and cognitive communication deficit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	

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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 11/26/24 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. She required supervision for most functional activities of daily living (ADL).</p> <p>The assessment documented the resident had no behavioral symptoms, including physical, verbal, or other, and there was no rejection of care.</p> <p>She was administered insulin injections, antianxiety, antidepressant, antibiotic, diuretic and hypoglycemic medications daily.</p> <p>III. Record review</p> <p>Review of Resident #1's comprehensive care plan, dated 9/15/23, revealed the following:</p> <p>-Resident #1 was admitted for long-term care with an intervention to evaluate the resident's motivation to return to the community.</p> <p>-Resident #1 declined to take her medications and get up in the mornings. The interventions included educating the resident and her family of the possible outcome(s) of not complying with treatment or care.</p> <p>The 1/10/25 nurses note revealed Resident #1 refused to take her medications because her stomach was upset and she was afraid she would throw up. The note documented that due to the management's previous instruction, the nurse proceeded to call the resident's representative, who came to the facility, and the resident took her medications.</p> <p>On 1/14/25 the ADON documented that on Friday, 1/10/25 at 3:45 p.m., Resident #1's representative requested the resident be sent to a hospital, because she said the resident was lethargic. The ADON further documented Resident #1 appeared to be at her baseline per nursing assessment.</p> <p>The 1/14/25 interdisciplinary team (IDT) note documented the IDT team discussed Resident #1's status at the hospital. It was determined with the regional nurse that the facility was not able to accept her back due to not being able to meet her needs, as she would not allow interventions to be put in place to accommodate her safety to prevent abuse physically and verbally. PACE (program of all-inclusive care for the elderly), the ombudsman, the resident's representative and the hospital caseworker were involved in the conversation.</p> <p>IV. Interviews</p> <p>The nursing home administrator (NHA) was interviewed on 1/29/25 at 9:30 a.m. The NHA said the IDT team made the decision to not permit Resident #1's return to the facility because of her medications refusals.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 1/30/25 at 1:20 p.m. LPN #1 said the resident's medication, lactulose, was very important for her to prevent hepatic encephalopathy. He said when Resident #1 declined to take this medication for a few days, she experienced a mental status change and required hospitalization. LPN #1 said the resident refused this medication because it made her nauseated in the morning.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Bear Creek Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  1685 S 21st St Colorado Springs, CO 80904	

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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A frequent visitor (FV) was interviewed on 1/30/25 at 2:34 p.m. The FV said she did not receive a facility-initiated discharge letter from the facility. She said Resident #1 and her representative did not receive the discharge notice/letter and were not aware of the appeal rights. The FV said the resident's representative would have liked Resident #1 to return to the facility, if she had a chance to appeal the facility's decision of discharge.</p> <p>The director of nursing (DON) and the ADON were interviewed together on 1/30/25 at 3:10 p.m.</p> <p>The DON said the IDT team made the decision of not accepting the resident back due to the resident refusing to take her medications, which led to her mental status changes and hospitalization s.</p>