

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Forest Street Compassionate Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3345 Forest St Denver, CO 80207	

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 an appropriate facility-initiated discharge procedure was followed for one (#105) of two residents reviewed for discharge out of 31 sample residents.</p> <p>Resident #105, who had a diagnosis of rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder and chronic pain, was admitted to the facility on [DATE] and involuntarily discharged to a homeless shelter on 2/20/24. The facility failed to provide preparations for a safe and orderly facility-initiated discharge or provide a reason for the discharge.</p> <p>Resident #105 began discharge planning with the facility on 1/11/24 during a care conference where his stated goal was to discharge to an assisted living facility (ALF). The last discharge plan discussion occurred on 2/16/24 when the facility offered to discharge the resident to homeless shelters and he declined this option. On 2/20/24 the facility had Resident #105 escorted from the facility by law enforcement. Resident #105 was crying and begging not to be kicked out of his home.</p> <p>The facility failed to provide the resident with a 30-day discharge notice or any form of written discharge notice and failed to provide written notice to the ombudsman of the discharge.</p> <p>Cross-reference F623 for failure to provide a written discharge notice to the ombudsman to include the reasons for the discharge.</p> <p>Additionally, the facility failed to provide Resident #105 with discharge instructions or his medications.</p> <p>Due to the facility's failures, Resident #105 was in and out of the hospital and homeless shelters following the involuntary discharge. Resident #105 suffered psychosocial harm stating he had a lot of confusion and anxiety when he first left and he was crying and begging at discharge not to be kicked out of his home. Resident #105 was angry about how the facility treated him and said it made him feel like he was a big problem and depreciated. Resident #105 said the experience was horrible when he was threatened with either discharging from the facility or going to jail.</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 Transfer or Discharge, Facility-Initiated policy and procedure, dated October 2022, was provided by the nursing home administrator (NHA) on 7/11/23 at 5:05 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>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"> -The specific reason for the transfer or discharge, including the basis; -The effective date of the transfer or discharge; -The specific location to which the resident is being transferred or discharged ; and, -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; -Information about how to obtain an appeal form; and, -How to get assistance in completing and submitting the appeal hearing request; -The notice of facility bed-hold and policies; -The name, address, and telephone number of the office of the state long-term care ombudsman; -The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental disabilities; and -The name, address and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. <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>Nurses notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.</p> <p>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:</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 basis for the transfer or discharge;</p> <p>-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; this facility's attempt to meet those needs; and the receiving facility's services that are available to meet those needs;</p> <p>-That an appropriate notice was provided to the resident and/or legal representative;</p> <p>-The date and time of the transfer or discharge;</p> <p>-The new location of the resident;</p> <p>-The mode of transportation;</p> <p>-A summary of the resident's overall medical, physical, and mental condition;</p> <p>-Disposition of personal effects;</p> <p>-Disposition of medications;</p> <p>-Others as appropriate or as necessary; and,</p> <p>-The signature of the person recording the data in the medical record.</p> <p>-However the above information was not documented in Resident #105's electronic medical record (EMR) (see record review below), and the resident and/or representative did not receive any written notice of an impending facility-initiated discharge.</p> <p>II. Resident #105</p> <p>A. Resident status</p> <p>Resident #105, age less than 65, was admitted on [DATE] and discharged on [DATE] to a homeless shelter.</p> <p>According to the February 2024 computerized physician orders (CPO), diagnoses included rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder and chronic pain.</p> <p>The 2/20/24 discharge 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 independent for all 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>The assessment documented active discharge planning was already occurring for the resident to return to the community and a referral had been made to the local contact agency.</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>-Discharge planning according to the residents goals and preferences was to discharge to an ALF. However, the facility suddenly discharged him to a homeless shelter against his wishes (see interviews and record review below).</p> <p>B. Resident interview</p> <p>Resident #105 was interviewed via phone on 7/11/24 at 12:28 p.m. Resident #105 said the facility discharged him with no written discharge notice or reason. He said the facility gave him no discharge instructions or his medications. He said the facility called the police on him when he did not want to go and said he would either go to jail or go to a homeless shelter.</p> <p>Resident #105 said the facility had retaliated against him because he had filed a complaint that the facility was cold and within a week he was told to leave. He said it was a horrible humiliating experience and made him feel like he was a huge problem and depreciated. He said the experience made him furious. He said he had been cold in the building and so he said something. He said he was not provided assistance by the ombudsman and he was not involved in selecting the new location to discharge to. He said he wanted to go to an assisted living facility and he said he was in the middle of that process when the facility suddenly discharged him without notice or reason.</p> <p>Resident #105 said he worked with a psychiatrist and had a lot of confusion and anxiety when he was discharged from the facility. He said he had to go back to the hospital. He said the homeless shelter where he went had put him on a list for housing assistance.</p> <p>C. Resident representative interview</p> <p>The resident's representative was interviewed via phone on 7/11/24 at 11:38 a.m. The representative said the facility initiated Resident #105's discharge and he was not treated properly. The representative said neither she nor the resident had received a written discharge notice or a reason for the discharge. She said at the time of the discharge, she was on facetime with the resident because she lived out of state and had screen recorded the resident crying and begging for the facility not to kick him out.</p> <p>The resident's representative said she was crying as she viewed how the resident was being treated. She said when Resident #105 would not leave, the facility called the police on him and the police forced him out.</p> <p>The resident's representative said she thought the facility was retaliating against the resident because he spoke up about things that concerned him during his stay, such as the heat being turned off and being cold in the building and his clothing coming back from the laundry not cleaned or with holes. The resident's representative said the discharge happened right after he said something and the facility forced him to leave without a written discharge notice. The resident's representative said since his discharge from the facility, the resident had been in and out of the hospital and homeless shelters.</p> <p>D. Frequent visitor (FV) 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>A frequent visitor (FV) was interviewed on 7/15/24 at 10:21 a.m. The FV said she did recall Resident #105. She said he was discharged for non payment and he did not want to apply for Medicaid. She said Resident #105 did not call her for assistance. She said she did not see the facility process the required discharge paperwork and no one followed up with her. She said the discharge process just got away. She said the facility was not consistent with their discharge processes and was changing social workers. The FV said she did not receive a written copy of the 30-day discharge notice.</p> <p>E. Record review</p> <p>The long term care (LTC) care plan, initiated 12/29/23, revealed Resident #105 planned to remain at the facility for LTC and may have needed time to adjust to his new environment. However, he would be asked about his interest in discharging from the facility on a quarterly assessment. Interventions included to assist the resident to activities as needed, and to monitor for signs and symptoms (s/s) of decrease in mood or s/s of depression and inform social services if noticed such as little interest in doing things or number of depressed episodes, or experiencing pain.</p> <p>-The care plan was not updated with a new discharge plan.</p> <p>Review of Resident #105's EMR revealed the following progress notes:</p> <p>The 1/11/24 care conference note revealed the resident planned to be discharged by the end of January 2024 and social services would meet the resident's discharge plan needs.</p> <p>The 1/18/24 psychosocial note revealed the resident would like to be discharged to the community independently or in an ALF. The resident had been made aware (company name) independent living had a short waiting list and had indicated he was interested in completing the application and the application was provided to the resident on 1/17/24.</p> <p>The 1/19/24 psychosocial note revealed the writer spoke to the ombudsman regarding the resident's interest in living in an ALF or an independent living facility. The ombudsman recommended (company name) ALF.</p> <p>The 1/25/24 psychosocial note revealed the ALF would come to do a resident assessment of Resident #105 on 1/29/24.</p> <p>The 1/30/24 psychosocial note revealed the resident would not be attending an assessment for (company name) ALF because the resident would be going to the independent living of (company name). The admission coordinator would be contacting the resident to relay the message to him.</p> <p>The 2/1/24 psychosocial note revealed the writer had met with the resident on 1/31/24 and discussed a tour of (company name) ALF. The resident had indicated that he liked the place and was willing to move forward with admission to the ALF. The resident was unsure of the admission to the new facility therefore the writer reached out to the admission coordinator via email and she had indicated that the potential admitted would be in about two weeks (mid-February 2024).</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 2/9/24 physician discharge visit note revealed the resident was being seen at the request of the facility administrator for a discharge visit. It revealed the resident suffered from chronic pain due to rheumatoid arthritis and spinal stenosis. It revealed the staff had been dealing with issues regarding behaviors with the resident. The police had been called by the NHA after the resident had an outburst and had yelled inappropriate racial statements and also stated he would kill the people sitting here and still get away with it.</p> <p>The note further revealed the police said they did not have enough reason to take him on a mental hold since he was not suicidal or homicidal and since he did not have a previous history, they could not detain him. The resident's health improved to the extent that the resident no longer needed the services of the facility and the resident would be discharged to a safe housing/shelter and the facility would provide transportation.</p> <p>The 2/9/24 CPO revealed the resident may discharge to safe housing/shelter.</p> <p>The 2/14/24 psychosocial note revealed the writer visited the resident to discuss his discharge plans and the resident was open to discuss his plans. When talking about the ALF location the resident was interested in going to, the resident stated he was not going there because they continued to ask him about another facility he had never been to. However when speaking to the ALF, the writer spoke with the admission coordinator and she had stated that the executive director had declined Resident #105's admission due to his behaviors. During the visit, the resident stated he was not depressed regarding the situation but continued to visit with his own therapist weekly. The resident's goal was to be cordial with others to meet his goal of being discharged to an ALF or independent living.</p> <p>The 2/16/24 psychosocial note revealed the facility met with the resident to discuss discharge plans. The facility offered to discharge him to homeless shelters and he declined this option. The plan was to follow up the following week for any further instructions needed to aid the resident in the discharge transition.</p> <p>The 2/17/24 nurses note revealed the police had been called by the resident to report that the facility's heater was turned off and the resident was cold. The police spoke with the resident and left. The nurse asked the resident if he was still cold and needed more blankets and he had said he was fine.</p> <p>The 2/20/24 at 7:13 a.m. psychosocial note revealed the writer had spoken with the resident's representative on 2/19/24 to discuss the resident's discharge plan. The representative had stated she would help find a location for the resident. The writer and the resident's representative planned to meet with the resident via computer facetime, and if possible with the resident's therapist, on 2/21/24 to discuss the discharge plan.</p> <p>The 2/20/24 at 10:02 a.m. psychosocial note revealed that, during the call on 2/19/24, the resident's representative had asked if the manager of the facility's ownership company could give her a call to understand what was going on at the facility. The writer had spoken to the CEO (chief operating officer) and CFO (chief financial officer) and addressed the concerns of the representative and they planned to call the resident's representative as requested.</p> <p>-The resident's representative revealed during her interview on 7/11/24, the company management had never given her a call.</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 2/20/24 at 3:49 p.m. nurses note revealed at approximately 3:50 p.m. Resident #105 was escorted from the facility accompanied by law enforcement. The resident was cooperative.</p> <p>The 2/20/24 at 4:46 p.m. psychosocial note revealed the resident was presented with multiple options when planning to discharge, however, he refused to comply with any option. The resident was discharged that day (2/20/24) and he refused to leave. The writer met with the resident along with a civilian emergency response team, clinicians and the police because of the resident's refusal to leave after being successfully discharged from the facility and the resident was considered to be trespassing. The administrative staff assisted with the process to have the resident transported to a homeless shelter where he would be able to coordinate housing with the shelter's available options.</p> <p>The 2/21/24 at 8:47 a.m. psychosocial note revealed the ombudsman was contacted on 2/20/24 about an emergency discharge of Resident #105 due to the ombudsman being a part of the discharge planning from the beginning.</p> <p>Review of Resident #105's EMR on 7/11/24 at 9:49 a.m. revealed the following:</p> <ul style="list-style-type: none"> -There was no discharge summary or assessment documentation; -There were no nurses note documentation of appropriate orientation and preparation of the resident prior to transfer or discharge; -There was no reason for the discharge documented in the record; and, -There was no written discharge notice documentation. <p>III. Staff interviews</p> <p>The regional operations consultant (ROC), the NHA, and the social services director (SSD) were interviewed together on 7/11/24 at 3:06 p.m. The NHA said she had started in the NHA position in May 2024 but she was at the facility in other capacities in the month of February 2024. She said the current SSD started in January of 2024. The NHA said the current SSD was fairly new at the time of Resident #105's discharge in February of 2024 but had help from another regional social services consultant who was now no longer with the company.</p> <p>The SSD said the facility initiated the discharge of Resident #105.</p> <p>The NHA said when the discharge process began, Resident #105 was in favor of discharging but she said, at the very end of the process, the discharge became facility-initiated. The NHA said the facility used a third party organization who worked with the community to assist with the discharge.</p> <p>The ROC said there were several factors for why Resident #105 was discharged but the main reason was because the resident was not happy at the facility.</p> <p>The NHA said the ombudsman talked to everyone to help the process. The NHA and the ROC said they did not know what the facility's policy was on discharge notification and they could not give a reason why the discharge was facility-initiated.</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 (#105) of two 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 31 sample residents.</p> <p>Specifically, the facility failed to provide Resident #105 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>Additionally, the facility failed to provide written notice to the ombudsman of Resident #105's facility-initiated discharge.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Transfer or Discharge, Facility-Initiated policy and procedure, dated October 2022, was provided by the nursing home administrator (NHA) on 7/11/23 at 5:05 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>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"> -The specific reason for the transfer or discharge, including the basis; <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>-The effective date of the transfer or discharge;</p> <p>-The specific location to which the resident is being transferred or discharged ; and,</p> <p>-An explanation of the resident's rights to appeal the transfer or discharge to the state, including:</p> <p>-The name, address, email and telephone number of the entity which receives such appeal hearing requests.</p> <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 #105</p> <p>A. Resident status</p> <p>Resident #105, age less than 65, was admitted on [DATE] and discharged on [DATE] to a homeless shelter. According to the February 2024 computerized physician orders (CPO), diagnoses included rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder, and chronic pain.</p> <p>The 2/20/24 discharge 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 independent for all 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>The assessment documented active discharge planning was already occurring for the resident to return to the community and a referral had been made to the local contact agency.</p> <p>-Discharge planning according to the residents goals and preferences was to discharge to an assisted living facility. However the facility suddenly discharged him to a homeless shelter against his wishes (see interviews and record review below).</p> <p>III. Record review</p> <p>-Record review revealed the facility failed to provide a written notice for the facility initiated discharge to Resident #105, to include his 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 (cross-reference F622 for transfer and discharge requirements).</p> <p>On 7/11/24 at 3:06 p.m documentation of the discharge notice that was provided to the resident and the written notification of the ombudsman were requested from the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Forest Street Compassionate Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3345 Forest St Denver, CO 80207	
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>-However, the facility failed to provide documentation of the discharge notice and notification to the ombudsman (see interviews below).</p> <p>Review of Resident #105's electronic medical record (EMR) revealed the following progress notes:</p> <p>The 2/20/24 at 3:49 p.m. nurses note revealed at approximately 3:50 p.m. Resident #105 was escorted from the facility accompanied by law enforcement. The resident was cooperative.</p> <p>The 2/20/24 at 4:46 p.m. psychosocial note revealed the resident was presented with multiple options when planning to discharge, however, he refused to comply with any option. The resident was discharged that day (2/20/24) and he refused to leave. The writer met with the resident along with a civilian emergency response team clinicians and the police because of the resident's refusal to leave after being successfully discharged from the facility and the resident was considered to be trespassing. The administrative staff assisted with the process to have the resident transported to a homeless shelter where he would be able to coordinate housing with the shelter's available options.</p> <p>The 2/21/24 at 8:47 a.m. psychosocial note revealed the ombudsman was contacted on 2/20/24 about an emergency discharge of Resident #105 due to the ombudsman being a part of the discharge planning from the beginning.</p> <p>Review of Resident #105's EMR on 7/11/24 at 9:49 a.m. revealed the following:</p> <ul style="list-style-type: none"> -There was no discharge summary or assessment documentation; -There were no nurses note documentation of appropriate orientation and preparation of the resident prior to transfer or discharge; -There was no reason for the discharge documented in the record; and, -There was no written discharge notice documentation. <p>IV. Staff interviews</p> <p>The social services director (SSD) was interviewed on 7/11/24 at 3:06 p.m. The SSD said he did not issue a written facility-initiated discharge notice to Resident #105 or the ombudsman.</p> <p>The NHA and the regional operations consultant (ROC) were interviewed together on 7/15/24 at 8:46 a.m. The NHA and the ROC said the facility did not issue a facility-initiated discharge notice to Resident #105 or provide written notice to the ombudsman. The NHA and the ROC said they did not know the reason why the facility discharged the resident or why the facility had not issued a 30-day discharge notice.</p>		