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	345077	A. BUILDING ______ B. WING ______	C 02/11/2019

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E 000	Initial Comments An unannounced recertification survey was conducted on 02/04/19 through 2/7/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID GWN511.	E 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622		3/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 02/28/2019

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.

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F 622	Continued From page 1 (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F 622		

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F 622 Continued From page 2

(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, and interviews with family and staff interviews, and interviews with the Nurse Practitioner (NP) and Physician's Assistant (PA), the facility initiated an inappropriate discharge of a resident who required 1 on 1 continual staff supervision and therapy services to an Assisted Living Facility (ALF) for 1 of 2 sampled residents (Resident #75) reviewed for discharges.

The findings include:

Resident #75 was admitted to the facility on 9/26/2018 with diagnoses to include dementia with behavioral disturbance, diabetes, adult failure to thrive, history of falls, difficulty walking and muscle weakness.

Physician orders for Resident #75 included an order dated 9/26/2018, that read Skilled Nursing Facility (SNF) services were required to be given on an inpatient basis because of the residents

F 622

F622
1-Interventions for affected resident:
No interventions for Resident #75 as the resident no longer resided in the facility
2- Residents identified as having the potential to be affected:
All residents who are discharged to home or discharged to another facility have the potential to be affected.
3-Systemic changes:

On 2/8/2019 an in service was conducted with the Social Worker by the Director of Nursing to review the criteria for appropriate discharges.

Beginning 2/8/2019 residents who are potential discharges or planned discharges will be reviewed by the Director of Nursing/Assistant Director of Nursing or designee to ensure appropriate discharge criteria is met. The discharge

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F 622	Continued From page 3 need for skilled nursing or rehab care on a continuing basis for conditions which required inpatient hospital admission prior to transfer to (SNF). Physician orders for Resident #75 included an order for Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) to screen as indicated, dated 9/26/2018. An order for PT clarification, dated 9/26/2018 that read Patient to be seen 5 times per week for 12 weeks for PT. An order for OT clarification, dated 9/27/2018 read: Patient to be seen 5 times per week for 12 weeks. An order for ST clarification, dated 9/27/2018 read: treat 5 times per week for 12 weeks. A review of Resident #75's care plan, initiated on 9/27/2018, included a Focus of limited physical mobility related to weakness, requiring assistance for ADL care daily. Interventions included assistance with bed mobility, transfer, meals, and ADLs as needed, and PT/OT to continue to evaluate and treat routinely or as needed. A nurse's note dated 9/27/2018 at 10:46 PM revealed the resident was alert and stable, with confusion and restlessness; the resident needed one to one care during the shift. No reason for the one to one care was documented in the note. A nurse's note dated 9/29/2018 at 12:02 AM revealed the resident was alert and stable, with confusion and restlessness; was on one to one care during the shift. No reason for the one to one care was documented in the note. A nurse's note dated 9/30/2018 at 9:50 AM revealed one to one care continued for the	F 622	must meet one or more of the following: (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. This review will be conducted daily Monday through Friday in the clinical meeting and will include review by the Director of Nursing/Assistant Director of Nursing or designee for clinical services, therapy services and Social Services. The review will be documented on the	

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Continued From page 4
resident safety, no behavior problems noted.

A nurse's note dated 10/1/2018 at 13:59 PM revealed one to one care continued at this time for safety, taking medications and meals without problems.

A Nurse Practitioner (NP) Interval history and physical note dated 10/1/2018, revealed nursing reported patient continues to try and get out of bed, requiring a sitter, patient remains confused.

A Social Worker (SW)e note dated 10/1/2018 revealed the SW spoke with the Director of the Assisted Living Facility (ALF) who indicated someone from the ALF would come the next day to assess the resident for re-admission, and according to the Director of the ALF, the resident met the criteria for re-admission. There were no other SW notes included in the resident's medical record.

Resident #75's 5-day Minimum Data Set (MDS) assessment dated 10/2/2018 revealed he had severe cognitive impairment, required extensive to total assist from staff for activities of daily living (ADL), and had falls prior to admission.

A nurse's note dated 10/2/2018 at 4:05 AM revealed one to one care continued at this time, resident resting quietly. No reason for the one to one care was documented in the note.

A review of Resident #75's Medication Administration Records (MAR) for 9/2018 and 10/2018 revealed blood glucose monitoring was conducted once a day on 9/26/2018 and 10/2/2018, and twice per day on 9/27/2018, 9/28/2018, 9/29/2018, 9/30/2018, and 10/1/2018.

F 622

Discharge Review Form.
4-Monitoring of the change to sustain systemic compliance ongoing
The review will be ongoing and audited weekly by the Director of Nursing or designee for 8 weeks and then monthly for 3 months. The review will continue and the need for auditing will be reevaluated at the end of the time specified.
Quality Assurance:
The discharge reviews will be ongoing daily Monday through Friday in the morning clinical/IDT meeting. The DON will report to the Quality Assurance and Performance Improvement (QAPI) meeting monthly times 3 months to ensure on going compliance and to determine the need for future audits. The Administrator will monitor the results presented to the QAPI Committee to ensure compliance.
The Administrator is the person responsible for implementing the Plan of Correction.

F 622 Continued From page 5 F 622

Resident #75's Interdisciplinary Discharge Summary dated 10/2/2018 revealed the following and was the only basis for discharge documented in the medical record:

The reason for discharge: returned to facility he was at prior to hospital admission

The reason for discharge diagnoses: not appropriate for this setting

The discharge potential: the resident needed a Memory Care Unit

Additional Nursing Service Notes: returned to facility prior to hospital admission, patient needs memory care unit.

An interview was conducted on 2/5/2019 at 2:21 PM with the family member (FM) of Resident #75. The FM stated she visited the resident when he was at the facility, but she had been sick for a couple of days, and when she called to see how he was doing, she was told Resident #75 had been transferred back to the ALF he had been at prior to his hospitalization. The FM stated she asked why and was told the facility could not provide for his needs as he needed 1 to 1 care. The FM stated she had not wanted the resident to go back to the same ALF he was at prior to his hospitalization because he had 3 falls while he was there. The FM stated if she had been notified, she would have informed the facility not to discharge Resident #75 from the facility.

On 2/6/2019 at 10:05 AM, an interview was conducted with the Social Worker (SW). The SW stated Resident #75 was admitted to the facility

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F 622	Continued From page 6 and needed one to one care. The SW stated Resident #75 was discussed at the morning clinical meeting daily, which was attended by the Interdisciplinary Team (IDT) which included the SW, Director of Nursing (DON), Administrator, Medical Records, Dietary Manager, Activity Director, and MDS nurse. Resident #75's needs for 1 to 1 care for being a fall risk were discussed. The SW stated there was an IDT consensus, with an urgency, that he be moved from the facility because they could not provide 1 to 1 care for the resident and could not meet his needs. The SW could not say who instructed her to find a facility to transfer the resident to, only that it was a IDT consensus, and it was urgent. The SW stated she found out the resident had been at a ALF prior to his admission to the hospital and she called that facility. The SW stated the facility responded to her they hadn't known where Resident #75 had gone after his hospitalization, but they had been looking for him. The SW stated she did not call the family of Resident #75 before he left the facility because she did not have a contact name or number in the resident's medical record. The SW stated she only found out the FMs name after the resident left, and then she put the information in the computer. The SW stated she did not set up home health or any type of therapy services for the resident since he was going to another facility. On 2/6/2019 at 10:31 AM, an interview was conducted with the Admissions Coordinator (AC), who stated she always documented a contact name, number and relationship for every resident that was admitted to the facility, prior to their arrival at the facility. The AC stated the Admissions Director (AD) worked on site at the hospital and justified the skilled service need prior	F 622		

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to admission. The AC conferenced the Admission Director per telephone, and the AD stated Resident #75 was admitted to the facility for therapy services.

On 2/6/2019 at 11:08 AM, an interview was conducted with the Occupational Therapist. The Occupational Therapist stated Resident #75 needed assistance with his ADLs due to his cognitive abilities more than his functional abilities. The Occupational Therapist stated his discharge assessments were not conducted, because the resident had an unscheduled discharge from the facility and not because he had reached any goals.

On 2/6/2019 at 11:20 AM, an interview was conducted with the Physical Therapist, who stated he had only worked with Resident #75 on 3 days. The Physical Therapist stated the resident was not discharged from therapy but had been transferred to another facility.

On 2/6/2019 at 11:31 AM, an interview was conducted with the Speech Therapist, who stated the resident was not discharged from Speech Therapy and she would have continued working with him, but he was discharged from the facility.

On 2/7/2019 at 9:54 AM, an interview was conducted with the nurse #1 who signed Resident #75's discharge paperwork to an ALF on 10/2/2018. The nurse stated she remember the resident was a fall risk, and someone was with him for 1 on 1 care around the clock. The nurse stated she did not remember an urgency to move the resident, but he became a priority because there were concerns that something could happen safety wise. The nurse stated he needed

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a facility that could provide one to one care for him.

On 2/6/2019 at 9:53 AM, an interview was conducted with the Nurse Unit Manager, who stated she understood from the SW that the nursing home where Resident #75 previously resided wanted him back. The Unit Manager stated the resident needed one to one care which they provided for him.

On 2/6/2019 at 2:10 PM, an interview was conducted with the MDS nurse who stated Resident #75 was at the facility for a total of 6 days, and that was not long enough to have a formal care plan meeting, but his issues were discussed in the IDT clinical meeting every morning. The MDS nurse stated the facility was trying to meet the resident's needs with one to one care and the nurses were just awesome with him because he was a fall risk and he would try and get up by himself. The MDS nurse stated she knew the facility was meeting his needs, and she had not expected him to be transferred.

On 2/6/2019 at 3:51 PM, an interview was conducted with the previous Administrator who stated he remembered the resident, and the facility was able to meet his needs, but understood that the resident wanted to go back to his previous ALF. The Administrator stated he did not discharge the resident with a 30-day discharge but could not remember the specifics, only that he thought the family wanted him back at the ALF. The Administrator stated if the resident had been on one to one care, he would have been appropriate for a 30-day discharge notice.

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On 2/6/2019 at 5:14 PM, an interview was conducted with the previous DON who stated she did not remember Resident #75.

On 2/7/2019 at 8:40 AM, an interview was conducted with the Nurse Practitioner (NP). The NP stated he signed the discharge order but did not know anything about his discharge because it was so long ago. The NP stated most likely the resident was discharged as urgent because any time there was a safety situation that someone needed one to one care, they would be sent out. The NP stated the facility was not a memory care unit and it was not a service they provide. The NP stated Resident #75 had dementia with behavioral issues, and he was an unsafe falls risk that required one to one care. The NP stated he did not tell the facility staff that care could not be provided.

On 2/6/2018 at 3:44 PM, an interview was conducted with the Assisted Living Facility Director (ALD) where Resident #75 had resided prior to his hospitalization. The ALD stated she received a call from the SW that Resident #75 was ready to be discharged back to their facility. The ALD stated she evaluated the resident on 10/1/2018, and the facility transferred Resident #75 to the ALF on 10/2/2018. The ALD stated he did not come with a referral for home health therapy. The Director further stated she was not informed by facility staff that Resident #75 required 1 to 1 staff to resident supervision while at the skilled facility.

An interview was conducted on 2/7/2019 at 1:02 PM with the Physician Assistant (PA) who worked for the ALF that Resident #75 was discharged to. The PA stated when Resident #75 was

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F 622	Continued From page 10 re-admitted to the ALF on 10/2/2018, his blood sugars were running high, and the PA instructed the ALF to check the blood sugars more often. The PA explained that even with the administration of insulin on 10/4/2018, it did little to help in lowering the resident's blood sugar, so he had the ALF send the resident to the hospital. On 2/11/2019 at 10:34 AM, an interview was conducted with the Administrator who started working at the facility on 10/3/2018 and was not employed at the facility at the time of Resident #75's discharge on 10/2/2018. He stated he expected discharges from the facility to be made timely with notification of the Physician and Responsible Party. The Administrator further stated Therapy personnel had a great deal of input on a resident's discharge based on the resident's goals and response to therapy.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		3/11/19

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§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) 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; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

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F 623	Continued From page 12 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 13 Based on record review, family and staff interviews, and Nurse Practitioner interview the facility failed to notify the resident's family and provide a 30-day discharge notice for a facility-initiated discharge of a cognitively impaired resident that was discharged to an Assisted Living Facility, for 1 of 2 residents (Resident #75) reviewed for discharge. The findings include: Resident #75 was admitted to the facility on 9/26/2018 with diagnoses to include dementia with behavioral disturbance, diabetes, adult failure to thrive, history of falls, difficulty walking and muscle weakness. Physician orders for Resident #75 included an order dated 9/26/2018, that read Skilled Nursing Facility (SNF) services were required to be given on an inpatient basis because of the residents need for skilled nursing or rehab care on a continuing basis for conditions which required inpatient hospital admission prior to transfer to (SNF). The resident's 5-day Minimum Data Set (MDS) assessment dated 10/2/2018 revealed he had severe cognitive impairment, required extensive to total assist from staff for activities of daily living (ADL), and had falls prior to admission. A nurse's progress note dated 10/2/2018 revealed Resident #75 was discharged on 10/2/2018. No documentation was found in Resident # 75's medical record including progress notes, physician orders, or discharge summary that the family was notified of the discharge.	F 623	F623 1-Interventions for affected resident: No interventions for Resident #75 as the resident no longer resided in the facility 2- Residents identified as having the potential to be affected: All residents who are discharged to home or discharged to another facility have the potential to be affected. 3-Systemic changes: On 2/8/2019 an in service was conducted with the Social Worker by the Director of Nursing to review the criteria for appropriate discharges and notification of impending discharges. Beginning 2/11/2019 all residents who are potential discharges or planned discharges will be reviewed by the Director of Nursing/Assistant Director of Nursing or designee to ensure appropriate responsible party and/or resident notification of impending discharge is completed and documented. The review will be documented on the Discharge Review Form and will include documentation from the DON and the SW on family notification, the reason for discharge and the date of the notification. This review will be conducted daily Monday through Friday in the clinical meeting and will include review by the Director of Nursing/Assistant Director of Nursing or designee for clinical services, therapy services and Social Services. The review will be documented on the Discharge Review Form.	

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An interview was conducted on 2/5/2019 at 2:21 PM with the family member (FM) of Resident #75. The FM stated she visited the resident when he was at the facility, but she had been sick for a couple of days, and when she called the facility to see how he was doing, she was told Resident #75 had been transferred to the Assisted Living Facility (ALF) he had been at prior to his hospitalization. The FM stated she asked them why and was told the facility could not provide for his needs as he needed 1 to 1 care. The FM stated she did not want the resident to go back to the same ALF because he had 3 falls while he was there. The FM stated if she had been notified, she would have informed the facility not to discharge Resident #75 from the facility.

On 2/6/2019 at 10:05 AM, an interview was conducted with the Social Worker (SW). The SW stated Resident #75 was admitted to the facility and needed one to one care. The SW stated there was an Interdisciplinary Team (IDT) consensus, with an urgency, that he be moved from the facility because they could not provide 1 to 1 care for the resident and could not meet his needs. The SW stated she found out the resident had been at an ALF prior to his admission to the hospital and she called that facility. The SW stated she did not call the family of Resident #75 before he was discharge from the facility because she did not have a contact name or phone number for the family in the resident's medical record. The SW stated she only found out the FM name after the resident left, so she put the family's contact information in the computer after the resident was discharged.

On 2/6/2019 at 10:31 AM, an interview was

F 623

4-Monitoring of the change to sustain systemic compliance ongoing
The review for discharge notification will be ongoing and audited weekly by the Director of Nursing/Assistant Director of Nursing or designee for 8 weeks and then monthly for 3 months. The review will continue and the need for auditing will be reevaluated at the end of the time specified.
Quality Assurance:
The discharge reviews which include responsible party and/or resident notification will be ongoing daily Monday through Friday in the morning clinical/IDT meeting by the DON/ADON or designee. The DON will report to the Quality Assurance and Performance Improvement (QAPI) meeting monthly times 3 months to ensure on going compliance and to determine the need for future audits. The Administrator will monitor the results presented to the QAPI Committee to ensure compliance.
The Administrator is the person responsible for implementing the Plan of Correction.

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F 623	Continued From page 15 conducted with the Admissions Coordinator (AC), who stated she always documented a contact name, number and relationship for every resident that was admitted to the facility, prior to their arrival at the facility. On 2/6/2019 at 1:53 PM, a second interview was conducted with the SW, who stated Resident #75 did not meet the criteria to stay at the facility and she called the ALF to have him transferred back to this facility. The SW stated the contact names and numbers of Resident #75's family were accessible in the computer at the time of the resident's discharge, but she did not call any of his family members to notify them before he was discharged to the ALF on 10/2/2018 or provide a 30-day discharge notice. The SW stated this resident's situation was different because there was an urgency to get the resident transferred. On 2/7/2019 at 8:40 AM, an interview was conducted with the Nurse Practitioner (NP). The NP stated he signed the discharge order but did not know anything about Resident #75's discharge because it was so long ago. The NP stated most likely the resident was discharged as urgent because anytime there was a safety situation that someone needed one to one care, they would be sent out. The NP stated the facility was not a memory care unit and it was not a service they provided. The NP stated Resident #75 had dementia with behavioral issues, and he was an unsafe falls risk that required one to one care. The NP stated he did not tell the facility staff that care could not be provided. On 2/6/2019 at 3:51 PM, an interview was conducted with the facility's previous Administrator, when Resident #75 was	F 623		

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F 623	Continued From page 16 discharged on 10/2/2018. The Administrator stated the facility was able to meet the resident's needs but understood that the resident wanted to go back to his previous ALF from staff. The Administrator stated he did not discharge the resident with a 30-day discharge but could not remember the specifics, only that he thought the family wanted him back at the ALF from reports he received from staff. On 2/11/2019 at 10:34 AM, an interview was conducted with the facility's current Administrator who stated he expected discharges from the facility to be made timely with notification of the Resident's Physician and Responsible Party.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 21 residents (Residents #75 and #26) reviewed for MDS inaccuracy. The findings included: 1.Resident #175 was admitted to the facility on 11/12/2018 with diagnoses to included Chronic Obstructive Pulmonary Disease, and post laminectomy (back surgery). The resident was discharged on 11/15/2018. Resident #175's discharge Minimum Data Set	F 641	F641 Accuracy of assessments Interventions for affected resident(s): Resident #175 Minimum Data Set (MDS) was modified on 2/7/2019 to reflect accurate coding per the Resident Assessment Instrument (RAI) manual. Resident #26 Minimum Data Set (MDS) was modified on 2/6/2019 to reflect accurate coding per the RAI Manual. Interventions for residents identified as having the potential to be affected: Discharge assessments completed in the previous 90 days were reviewed for accuracy of coding A2100 of the discharge assessment. Assessments	3/11/19

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(MDS) assessment dated 11/15/2018 revealed under section A, his discharge status was to an acute hospital.

A nurse's discharge note dated 11/15/2018 revealed the resident was discharged to his home and accompanied by his wife, per his request.

A discharge recapitulation noted revealed Resident #175 wanted to return home, and stated he no longer needed skilled nursing. The resident was discharged home with home health.

On 2/7/2019 at 11:23 AM, an interview was conducted with the MDS nurse who stated the hospital discharge was a data entry error and Resident #175 was discharged to his home.

On 2/7/2019 at 11:09 AM, an interview was conducted with the Administrator who stated he expected staff to follow established guidelines and code the MDS appropriately.

2.Resident # 26 was admitted to the facility on 10/29/2014 with diagnoses to include neuromuscular dysfunction of bladder and Parkinson's Disease.

Her quarterly Minimum Data Set (MDS) assessment dated 12/18/2018 revealed her cognition to be intact. The MDS section H listed an indwelling catheter, and the resident was always incontinent of bladder.

An observation conducted on 2/5/2019 revealed Resident #26 to have a catheter and it was attached to the bed with a privacy cover.

F 641

noted to be coded inaccurately will be modified per the RAI manual with a completion date of 3/1/2019.
An audit was completed on all current residents that have indwelling catheters (reviewing their 2 most recent MDS's on 2/8/2019), no further inaccuracies were noted.
Systemic Change:
On February 7, 2019 education was completed by the Clinical Process Analyst on accuracy of assessments per the RAI manual with the MDS nurse. As of February 26, 2019 and moving forward, 3 MDS discharge assessments per week will be audited by the Director of Nursing (DON) x 3 months for accuracy of location of discharge.
On February 8, 2019 education was completed by the Clinical Process Analyst on accuracy of assessments per the RAI manual with the MDS nurse. As of February 26, 2019 and moving forward, the DON will complete a weekly audit of completed MDS assessments to include those residents that having indwelling catheters to ensure accurate coding of item set H0300.
Monitoring the change to sustain system compliance ongoing:
The Director of Nursing will report the results of the audits to the QA committee for further review and recommendation monthly for three months and as deemed necessary thereafter.

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F 641	Continued From page 18 On 2/6/2019 at 2:32 PM, an interview was conducted with the MDS nurse who stated Resident #26 always had an indwelling catheter since admission to the facility on 10/29/2014. The MDS nurse further stated the resident was not incontinent of bladder, and that was an error on the 12/18/2018 MDS and she would correct it. On 2/7/2019 at 11:09 AM, an interview was conducted with the Administrator who stated he expected staff to follow established guidelines and code the MDS appropriately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		3/11/19

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F 656	Continued From page 19 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for 1 of 5 sampled residents reviewed who received antidepressant medications (Resident #72). The findings included: Resident # 72 was admitted to the facility on 7/19/18 with diagnoses of Insomnia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and Dementia. A review of the physician orders dated 8/31/18 revealed an order for Trazodone HIC tablet 50 mg. Give one tablet by mouth at bedtime for insomnia. Review of Resident #72's current care plan revealed a care plan was not developed to address the resident's use of an antidepressant medication.	F 656	F656 Development of Care Plan Interventions for affected resident: Resident #72 care plan was updated on 2/6/19 to reflect the antidepressant. Interventions for residents identified as having the potential to be affected: A review of residents who receive antidepressant medications was conducted on 2/8/2019 by the Director of Nursing and the MDS nurse to ensure the development of antidepressant care plans. Care plans were updated as deemed necessary. Systemic Change: On February 7, 2019 the MDS nurse was re-educated by the Clinical Process Analyst on the development of care plans. As of February 26, 2019 and moving forward, 3 care plans of residents receiving an antidepressant will be	

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F 656	Continued From page 20 A review of the Minimum Data Set (MDS) completed on 01/19/19 identified the resident as cogitatively intact. She was noted to have a diagnoses of insomnia and had received an antidepressant medication on 7 of 7 days during the MDS review period. Review of Resident #72's February 2019 Medication Administration Record on 2/06/19 revealed the resident received Trazodone HCL each night from 2/1/19 to 2/05/19. In an interview on 2/6/19 at 3:19 PM the MDS Coordinator RN revealed when a resident is first admitted she would look at the physician orders and take the care plan directly from their orders. She revealed she missed the Trazodone for insomnia for Resident #72 and would update the resident's care plan right away to include the resident was receiving an antidepressant medication. During an interview on 2/6/19 at 3:50 PM the Director of Nursing revealed she expected any resident receiving an antidepressant would have a care plan for it.	F 656	audited per week by the Director of Nursing (DON) x 3 months. Monitoring the change to sustain system compliance ongoing: The Director of Nursing will report the audit findings to the QA committee for further review and recommendations monthly for three months and as deemed necessary thereafter.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		3/11/19

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F 660	Continued From page 21 process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who	F 660		

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F 660	Continued From page 22 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, and interviews with the Nurse Practitioner (NP), and Physician's Assistant (PA) the facility failed to develop a discharge plan which addressed the residents needs and involved the resident's family, for a resident who received 1:1 care and rehabilitation therapy services at the facility, and was discharged to an Assisted Living Facility for 1 of 2 sampled residents (Resident #75) reviewed for discharge. The findings include:	F 660	F660 1-Interventions for affected resident: No interventions for Resident #75 as the resident no longer resided in the facility 2- Residents identified as having the potential to be affected: All residents who are discharged to home or discharged to another facility have the potential to be affected and will be reviewed by the interdisciplinary team	

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Resident #75 was admitted to the facility on 9/26/2018 with diagnoses to include dementia with behavioral disturbance, diabetes, adult failure to thrive, history of falls, difficulty walking and muscle weakness.

Physician orders for Resident #75 included an order dated 9/26/2018, that read Skilled Nursing Facility (SNF) services were required to be given on an inpatient basis because of the residents need for skilled nursing or rehab care on a continuing basis for conditions which required inpatient hospital admission prior to transfer to (SNF).

Physician orders for Resident #75 included an order for Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) to screen as indicated, dated 9/26/2018. An order for PT clarification, dated 9/26/2018 that read Patient to be seen 5 times per week for 12 weeks for PT. An order for OT clarification, dated 9/27/2018 read: Patient to be seen 5 times per week for 12 weeks. An order for ST clarification, dated 9/27/2018 read: treat 5 times per week for 12 weeks.

A review of Resident #75's care plan, initiated on 9/27/2018 did not include any focus or goals for discharge.

A review of Resident #75's Medication Administration Records (MAR) for 9/2018 and 10/2018 revealed blood glucose monitoring was conducted once a day on 9/26/2018 and 10/2/2018, and twice per day on 9/27/2018, 9/28/2018, 9/29/2018, 9/30/2018, and 10/1/2018.

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Monday through Friday in the morning clinical meeting.
3-Systemic changes:

On 2/8/2019 an in service was conducted with the Social Worker by the Director of Nursing to review the criteria for appropriate discharges, the discharge planning process to include the responsible party and the notification of the responsible party.

Beginning 2/8/2019 residents who are potential discharges or planned discharges will be reviewed Monday through Friday in the daily clinical meeting to ensure a discharge plan is developed by the Interdisciplinary team. The reviews will be documented on the new Discharge review form. The discharge form will include input from Clinical Services, Therapy Services and Social Services.

This review will be conducted daily Monday through Friday in the clinical meeting and will include review by the Director of Nursing/Assistant Director of Nursing or designee for clinical services, therapy services and Social Services. The review will be documented on the Discharge Review Form.
4-Monitoring of the change to sustain systemic compliance ongoing
The review will be ongoing and audited weekly by the Director of Nursing or designee for 8 weeks and then monthly for 3 months. The review will continue and the need for auditing will be reevaluated at the end of the time specified.

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	345077	A. BUILDING ______ B. WING ______	C 02/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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Resident # 75's 5-day Minimum Data Set (MDS) assessment dated 10/2/2018 revealed he had severe cognitive impairment, required extensive to total assist from staff for activities of daily living (ADL), and had falls prior to admission.

A nurse's progress note dated 10/2/2018 revealed Resident #75 was discharged on 10/2/2018.

Review of Resident #75's medical record revealed there was no discharge plan developed by staff for Resident #75.

Resident #75's Interdisciplinary Discharge Summary dated 10/2/2018 revealed the following and was the only basis for discharge documented in the medical record:

The reason for discharge: returned to facility he was at prior to hospital admission

The reason for discharge diagnoses: not appropriate for this setting

The discharge potential: the resident needed a Memory Care Unit

Additional Nursing Service Notes: returned to facility prior to hospital admission, patient needs memory care
unit

No documentation was found in Resident # 75's medical record including progress notes, physician orders, or discharge summary that the family was notified of the discharge.

An interview was conducted on 2/5/2019 at 2:21

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Quality Assurance:
The discharge reviews will be ongoing daily Monday through Friday in the morning clinical/IDT meeting. The DON will report to the Quality Assurance and Performance Improvement (QAPI) meeting monthly times 3 months to ensure on going compliance and to determine the need for future audits. The Administrator will monitor the results presented to the QAPI Committee to ensure compliance.
The Administrator is the person responsible for implementing the Plan of Correction.

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PM with the family member (FM) of Resident #75. The FM stated she visited the resident when he was at the facility, but she had been sick for a couple of days, and when she called the facility to see how he was doing, she was told Resident #75 had been transferred to the Assisted Living Facility (ALF) he had been at prior to his hospitalization. The FM stated she asked them why and was told the facility could not provide for his needs as he needed 1 to 1 care. The FM stated she had not wanted the resident to go back to the same ALF because he had 3 falls while he was there. The FM stated she did not have any meetings or discussions with the facility staff concerning the resident's discharge plans or goals while the resident was at the facility. The FM stated if she had been notified of Resident #75's discharge, she would have informed the facility not to discharge Resident #75 from the facility.

On 2/6/2019 at 1:53 PM, an interview was conducted with the Social Worker (SW), who stated Resident #75 did not meet the criteria to stay at the facility and she called the ALF to have him transferred back to this facility. The SW stated the contact names and numbers of Resident #75 were in the computer at the time of the resident's discharge, but she did not call any family members before he was transferred. The SW stated this resident's situation was different because there was an urgency to get the resident transferred. The SW further stated no initial care plan meeting or discharge plan meetings were conducted with the family of Resident #75 after he was admitted to the facility. The SW stated normally the meetings were scheduled within the first 72 hours of admission, but the facility had a change of Administration personnel and she did

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not schedule the meeting, and no discharge plan was developed for Resident #75. Additionally, the SW stated she did not make a referral for any therapy services for the resident because he was going to another facility.

On 2/7/2019 at 8:40 AM, an interview was conducted with the Nurse Practitioner (NP). The NP stated he signed the discharge order but did not know anything about his discharge because it was so long ago. The NP stated most likely the resident was discharged as urgent because any time there was a safety situation that someone needed one to one care, they would be sent out. The NP stated the facility was not a memory care unit and it was not a service they provide. The NP stated Resident #75 had dementia with behavioral issues, and he was an unsafe falls risk that required one to one care. The NP stated he did not tell the facility staff that care could not be provided.

An interview was conducted on 2/7/2019 at 1:02 PM with the Physician Assistant (PA) who worked for the ALF that Resident #75 was discharged to. The PA stated when Resident #75 was re-admitted to the ALF on 10/2/2018, his blood sugars were running high, and the PA instructed the ALF to check the blood sugars more often. The PA explained that even with the administration of insulin on 10/4/2018, it did little to help in lowering the resident's blood sugar, so he had the ALF send the resident to the hospital.

On 2/6/2018 at 3:44 PM, an interview was conducted with the Assisted Living Facility Director (ALD) where Resident #75 had resided prior to his hospitalization and was admitted to on 10/02/18. The ALD stated she received a call

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F 660	Continued From page 27 from the SW that Resident #75 was ready to be discharged back to their facility. The ALD stated she evaluated the resident on 10/1/2018, and the facility transferred Resident #75 to the ALF on 10/2/2018. The ALD stated he did not come with a referral for therapy services. The Director further stated she was not informed by facility staff that Resident #75 required 1 to 1 staff to resident supervision while at the skilled facility. An interview was conducted on 2/11/2019 at 10:34 AM with the facility's current Administrator. The Administrator stated he expected a resident's discharge plan to begin shortly after admission and developed further based on the resident's needs and involvement with the family.	F 660		