STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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F 000	INITIAL COMMENTS A complaint investigation was completed 10/23/19 through 10/24/19. 2 of the 4 complaint allegations were substantiated resulting in deficiencies (F622, F625, F626)	F 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		11/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2019

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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 reviews, family interview and physician and staff interviews, the facility failed to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 3 residents reviewed for facility-initiated transfer (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 11/21/17 with diagnoses that included hepatic encephalopathy (an altered level of consciousness as a result of liver failure), atrial fibrillation, respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues), anxiety and depression. Her payor status was listed as Medicare and Medicaid. Review of the medical record from March 2019 to present revealed Resident #1 had frequent episodes of yelling out for staff members to stay in her room, increased anxiety when left alone in	F 622	Corrective action for resident #1 as cited cannot be obtained as the resident no longer resides at the facility. An audit was completed on 11/13/2019 for a 3-month period. Results of the audit concluded that the facility had no facility-initiated transfers or discharges, during the period. Discharges are typically due to resident condition improvement, resident/family request, or based on emergent situations. Nursing Home Notice of Transfer/Discharge forms are sent with residents, at time of transfer, for residents that are sent to the hospital for emergent transfers. All Nursing Home Notice of Transfer/Discharge forms are then sent to the Ombudsman, at least monthly, per regulatory requirements. The facility currently sends a Nursing Home Notice of Transfer/Discharge form	

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F 622	Continued From page 3	F 622		

her room, fixating on whether her oxygen was working or not being in the center of the bed as well as nonsensical questions to the staff and fear of dying.

A review of the quarterly Minimum Data Set (MDS) dated 8/20/19 revealed the resident had moderate cognitive impairment, was able to make her needs known and understood others. She had displayed verbal behaviors directed towards other and other behavioral symptoms daily during the 7 day look back period. She required setup supervision for eating; extensive assistance from staff for bed mobility, dressing, toileting, hygiene and total assistance from staff for transfers and bathing.

Review of the care plan dated 8/21/19 included problem areas of delusions and hallucinations at times, believing in occurrence of false events and seeing people in her room, requiring assistance from staff for all ADL's with frequent demanding attitude, threatening to throw self on the floor if staff left her alone, periods of difficulty sleeping, frequent yelling out for staff to come sit with her. She was also care planned for falls risk and the use of antianxiety, antidepressant and antipsychotic medications.

The most recent MDS was coded as a discharge assessment with return anticipated and was dated 8/26/19.

A review of the nurse's notes completed by Nurse #1, dated 8/26/19 and timed 6:44 AM, revealed Resident #1 had been transferred to the hospital via Emergency Medical Services (EMS) on 8/26/19. The resident was documented as having a fall with a hematoma and abrasion to

with the resident to the hospital for emergent transfers. The facility will adjust to the current process by also mailing a Nursing Home Notice of Transfer/Discharge forms to the resident representative, the business day following resident transfers/discharges, until regulatory changes make this no longer necessary. CMS has proposed changes to the current system regarding transfer and discharge notification regulations, changes are expected to take place on November 28, 2019. The proposed CMS changes apply to resident/family-initiated transfers; these transfers will no longer require a Nursing Home Notice of Transfer/Discharge form to be provided, pending that proposed changes are initiated.

A Quality Assurance (QA) tool, Notice of Transfer/Discharge Form Audit Tool was created to monitor appropriate completion and delivery of transfer/discharge notification and to maintain regulatory compliance. Utilizing the QA tool, monitoring will be completed for all residents with transfer/discharge from the facility. Audits will be completed by the Medical Records Clerk, weekly for 3 months and monthly for 3 months. The 2019 Resident Discharge QA Team, which consists of the Administrator, Director of Nursing, Social Worker, Director of Admissions, and Medical Records Clerk, will meet weekly to discuss findings of on-going audits and corrective actions for 6 months from the date of alleged compliance to ensure deficient practice

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F 622	Continued From page 4 her forehead and when the physician was made aware an order was obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's responsible party had been notified via phone about the resident being sent to the ER. A Hospital Discharge Summary dated 9/7/19 revealed Resident #1 presented to the ER from the facility on 8/26/19 following a fall. She was admitted for further treatment of pneumonia and rapid Atrial Fibrillation (irregular heartbeat). She was discharged to a Long-Term Acute Care Hospital for continued Intravenous (IV) Lasix twice a day. A Long-Term Acute Care (LTAC) Hospital Discharge Summary dated 9/26/19 revealed Resident #1 was transferred from the hospital on 9/7/19 for continuation of respiratory support, IV Lasix, nutritional support and physical therapy. During her stay at the LTAC, Resident #1 had increased confusion and delirium requiring medication adjustments to correct ammonia levels. Once the levels returned to normal her mental status improved. She was followed by a psychiatrist as well as therapy and a dietician. She had completed her course of IV Lasix and was on an oral tablet at the time of discharge. Resident #1 was diagnosed with a urinary tract infection (UTI) prior to her anticipated discharge date and required treatment with an IV antibiotic. She would need 3 more days of the IV medication after discharge from the LTAC. The SNF had provided her with IV antibiotics in the past. Her condition at the time of discharge was described as stable with disposition to a SNF. Discharge instructions read in part: to be followed by the facility physician, Oxygen at 2 liters via nasal	F 622	does not recur. The Administrator will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Administrator will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled January 21, 2020.	

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F 622	Continued From page 5	F 622		

cannula, Lasix 40 milligrams (mg) by mouth twice a day, Meropenem (an antibiotic) 1 gram IV twice a day for 3 days for treatment of a UTI and ammonia levels to be monitored. A narrative note by the Case Manager dated 9/13/19 at 12:43pm indicated the discharge disposition would be back to prior Skilled Nursing Facility (SNF) with an anticipated transition date of 9/24/19. Review of a narrative note by the Case Manager dated 9/16/19 at 3:00pm revealed a clinical update was faxed to the facility and per the facility's admissions coordinator, they could no longer meet the patient's needs. The family was informed and provided a list of Skilled Nursing Facilities. The resident was subsequently discharged to another SNF on 9/26/19.

On 10/23/19 at 12:50pm an interview occurred with Nurse #2. She indicated the facility was able to provide care and services to Resident #1, but the resident had daily episodes of anxiety and yelling out when she was alone in her room as well as the resident's family had been noncompliant with medication aspects of the resident's care.

An interview was conducted on 10/23/19 at 1:07pm with Resident #1's responsible party (RP). He stated he had called the facility about two weeks after the resident had gone to the hospital and spoke with the Social Worker to inquire about a bed hold since he knew it could be a few more weeks until Resident #1 was ready to come back and was told "No. That's not an option" and just expected the resident would have been readmitted to the facility as before. The RP further stated he had met with the Administrator on 9/16/19 and was told the facility was not readmitting the resident due to her continued

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F 622	Continued From page 6	F 622		

behaviors and the family's resistance to medication management. He added he had not received any written documentation from the facility.

On 10/23/19 at 2:45pm an interview was held with the Administrator. He stated typically when a resident was discharged to the hospital, the physician and family are made aware, a packet of information about the resident with bed hold information was sent out with the resident, a staff member followed up with the hospital to clarify if the resident was going to be admitted and the resident's family is contacted the following day to discuss bed hold. He further stated the RP called the facility about 2 weeks after the resident was hospitalized inquiring about a bed hold, but felt it was "unethical to take the bed hold money when we felt we could no longer manage her". He added that due to her continued behaviors, the danger of her self-inflicted fall, disrupting other residents and staff when she was anxious and family resistance to medication management the facility could no longer meet her needs.

An interview occurred with the Social Worker on 10/23/19 at 3:33pm. She was able to recall speaking with the responsible party when he called about two weeks after the resident was transferred to the hospital and his inquiry regarding a bed hold. She stated she discussed it with the Administrator and relayed that a bed hold was not possible.

On 10/23/19 at 3:50pm an interview was conducted with the Director of Admissions. She explained that she had started working at the facility at the beginning of August 2019 and did not have any conversations related to Resident

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F 622	Continued From page 7	F 622		

#1. She stated typically information about bed hold was sent out with the resident when they were transferred to the ER and she followed up with the responsible party to discuss bed hold the next business day. She further stated no documentation occurred or paperwork obtained when she discussed bed holds.

An interview occurred with the Clinical Specialist from the nursing home on 10/23/19 at 4:01pm. She recalled looking at the clinical information from the LTAC Hospital and the resident was refusing to wear the Bilevel Positive Airway Pressure Machine (BiPAP-a non-invasive therapy for people suffering from sleep apnea) but she had refused to wear one at the facility as well, but her behaviors continued and was being followed by psychiatry at the LTAC. She confirmed the resident was seen by a Psychiatric Nurse Practitioner while a resident in the facility. She stated the facility was able to provide care and services to Resident #1, but since she was still exhibiting behavioral issues and due to the family noncompliance with medication management the facility felt they could no longer meet her needs. She was able to acknowledge the resident had not been placed in a nursing home with special features to provide care to the resident.

On 10/24/19 at 8:20am an interview was conducted with the Administrator and Chief Operations Officer. The Administrator stated Resident #1 did not receive a 30-day discharge notice. They both stated the facility felt Resident #1 was not stable enough for readmission due to her multiple behavioral issues and the family's resistance to medication management. They further stated, Resident #1 was disruptive to the other residents when they were trying to sleep,

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F 622	Continued From page 8 and the staff endured constant outbursts from the family. A phone interview occurred with the Facility Psych Nurse Practitioner on 10/24/19 at 11:12am. She recalled working with Resident #1 on several occasions regarding her anxiety as well as talking with the Resident's RP. She added the RP was receptive to the medication management changes they were pursuing to help with the severe anxiety and verbal outbursts but was aware of her liver disease and the caution that had to be taken regarding medications. A phone interview occurred with the Medical Director on 10/24/19 at 12:35pm. He was familiar with Resident #1 and stated she had lots of medical issues but felt the facility was managing her behaviors appropriately as she needed lots of attention as well as the family issues.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		11/14/19

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F 625	Continued From page 9 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, family and staff interviews, the facility failed to provide written notification to the resident's responsible party regarding bed hold when the resident was hospitalized for 1 of 3 residents reviewed for discharge (Resident #4). The findings included: Resident #4 was originally admitted to the facility on 3/22/16 with diagnoses that included chronic respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues), chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). Review of Resident #4's MDS revealed a discharge assessment dated 9/28/19 and marked as return anticipated. The resident was coded as having been discharged to the acute hospital as an unplanned discharge. A cognitive assessment was not completed, and the resident was coded as being independent with decision making.	F 625	Corrective action for resident #4 as cited cannot be obtained as the resident discharged from the hospital and was re-admitted to the facility. An audit was completed on 11/13/2019 for a 3-month period. Results of the audit concluded that the facility process for distributing bed hold agreements and calling family members for follow-up related to bed hold was changed by an employee, who is no longer employed by the facility. Corrective action will be obtained by changing the process to route bed hold agreements and how follow up with family members will be obtained. The facility currently notifies residents or resident representative of the bed hold process upon admission. A facility representative, typically discharging nurse sends a Bed Hold Agreement form with the resident to the hospital for emergent transfers. The facility will resume the	

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F 625	Continued From page 10 A review of a nurse's note completed 9/28/19, revealed Resident #4 had been discharged to the hospital via EMS at 9:55 pm on 9/28/19. The resident was documented as having a fall with a laceration present behind the right ear. When the physician was made aware an order was obtained to send the resident to the ER for further evaluation. The responsible party had been notified via phone about the resident being sent to the ER. The resident was documented as being alert and responsive to verbal stimuli and did not appear to be in any distress at the time of the transfer. On 10/23/19 at 3:50pm an interview was conducted with the Director of Admissions. She stated typically information about bed hold was sent out with the resident and she followed up with the responsible party to discuss bed hold the following business day. She further stated no documentation occurred or paperwork obtained when she discussed bed holds. She was unable to confirm if she had spoke with the responsible party regarding a bed hold. On 10/24/19 at 8:20am an interview occurred with the Administrator. He stated he was not aware if the resident's responsible party received or was made aware of the possibility of a bed hold. He further stated typically when a resident was discharged to the hospital, the responsible party and physician were made aware, a packet of information about the resident with bed hold information was sent with the resident, a staff member followed up with the hospital to clarify if the resident was going to be admitted and then the responsible party would be contacted to discuss a bed hold.	F 625	previously discontinued process of calling the resident (if applicable) or the resident's representative to offer a bed hold, the business day following resident transfers/discharges. Communication regarding bed hold conversations, including acceptance, refusal, or repeat contact attempts will be documented on a log created by the facility, the "Bed Hold Communication Log." A Quality Assurance (QA) tool, "Bed Hold Communication Log" was created to monitor appropriate completion, delivery, and communication regarding bed holds for transferred residents, to maintain regulatory compliance. Utilizing the QA tool, monitoring will be completed for all residents with transfer from the facility. Audits will be completed by the Admissions Coordinator, weekly for 3 months and monthly for 3 months. The "2019 Resident Discharge QA Team," which consists of the Administrator, Director of Nursing, Social Worker, Director of Admissions, and Medical Records Clerk, will meet weekly to discuss findings of on-going audits and corrective actions for 6 months from the date of alleged compliance to ensure deficient practice does not recur. The Administrator will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Administrator will report	

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F 625	Continued From page 11 An interview was conducted on 10/24/19 at 9:44am with Resident #4's responsible party. The responsible party (RP) stated she had not received written notification from the facility regarding the bed hold information nor did she discuss the possibility of a bed hold with any staff member.	F 625	findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled January 21, 2020.	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626		11/14/19

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F 626	Continued From page 12 § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview and physician and staff interviews, the facility failed to permit a resident to return to the facility from the hospital for 1 of 3 residents reviewed for discharge (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 11/21/17 with diagnoses that included hepatic encephalopathy (an altered level of consciousness as a result of liver failure), atrial fibrillation, respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues), anxiety and depression. Her payor status was listed as Medicare and Medicaid. Review of the medical record from March 2019 to present revealed Resident #1 had frequent episodes of yelling out for staff members to stay in her room, increased anxiety when left alone in her room, fixating on whether her oxygen was working or not being in the center of the bed as well as nonsensical questions to the staff and fear of dying. A review of the quarterly Minimum Data Set (MDS) dated 8/20/19 revealed the resident had moderate cognitive impairment, was able to make her needs known and understood others. She	F 626	Corrective action for resident #1 as cited cannot be obtained as the resident no longer resides at the facility. The facility Administrator last spoke to the resident's family on 9/16/2019; during this conversation it was made clear that this resident was not appropriate for re-admission to the facility, at that time. Physicians notes from the Long-Term Acute Care Hospital (LTACH) confirm the stance of the facility Administrator that the resident was not appropriate for Skilled Nursing Facility (SNF) level of care. The physician's statement, dated 9/20/2019, reads: "It remains reasonable and medically necessary for patient continue with long-term acute care hospitalization for comorbidity management rehabilitation needs." Family did not directly communicate with the facility regarding readmission following the meeting on 9/16/2019. An audit was completed on 11/13/2019 for a 3-month period. Results of the audit concluded that the facility had not failed to permit any other resident to return to the facility from the hospital, during the review period. Discharges to the hospital are due to resident need, family request, or based	

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F 626	Continued From page 13 had displayed verbal behaviors directed towards other and other behavioral symptoms daily during the 7 day look back period. She required setup supervision for eating; extensive assistance from staff for bed mobility, dressing, toileting, hygiene and total assistance from staff for transfers and bathing. The most recent MDS was coded as a discharge assessment with return anticipated and was dated 8/26/19. A review of the nurse's notes completed by Nurse #1, dated 8/26/19 and timed 6:44 AM, revealed Resident #1 had been transferred to the hospital via Emergency Medical Services (EMS) on 8/26/19. The resident was documented as having a fall with a hematoma and abrasion to her forehead and when the physician was made aware an order was obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's responsible party had been notified via phone about the resident being sent to the ER. A Hospital Discharge Summary dated 9/7/19 revealed Resident #1 presented to the ER from the facility on 8/26/19 following a fall. She was admitted for further treatment of pneumonia and rapid Atrial Fibrillation (irregular heartbeat). She was discharged to a Long-Term Acute Care Hospital for continued Intravenous (IV) Lasix twice a day. A Long-Term Acute Care (LTAC) Hospital Discharge Summary dated 9/26/19 revealed Resident #1 was transferred from the hospital on 9/7/19 for continuation of respiratory support, IV Lasix, nutritional support and physical therapy.	F 626	on other emergent situations. The nursing home does not have a pattern of refusing to re-admit SNF appropriate residents following hospital transfers. The facility will allow residents to re-admit following a hospital transfer or initiate a Nursing Home Notice of Transfer/Discharge form while the resident is in the hospital. If a Nursing Home Notice of Transfer/Discharge is initiated, the resident will be permitted to re-admit from the hospital for the remaining portion of the 30-day discharge notice, as required by regulation. Facility representatives were unaware that Nursing Home Notice of Transfer/Discharge form could be initiated while the resident was not in the facility. Correcting the Notice of Transfer/Discharge process shall also assist with correcting this alleged deficiency. A Quality Assurance (QA) tool, “Re-Admit Following Hospital Transfer Audit Tool” was created to monitor appropriate re-admission of residents following a hospital transfer to maintain regulatory compliance. Utilizing the QA tool, monitoring will be completed for all residents with hospital transfers from the facility. Audits will be completed by the Admissions Coordinator, weekly for 3 months and monthly for 3 months. The “2019 Resident Discharge QA Team,” which consists of the Administrator, Director of Nursing, Social Worker, Director of Admissions, and Medical	

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F 626	Continued From page 14 During her stay at the LTAC, Resident #1 had increased confusion and delirium requiring medication adjustments to correct the ammonia levels. Once the levels returned to normal her mental status improved. She was followed by a psychiatrist as well as therapy and dietician. She had completed her course of IV Lasix and was on an oral tablet at the time of discharge. Resident #1 was diagnosed with a urinary tract infection (UTI) prior to her anticipated discharge date and required treatment with an IV antibiotic. She would need 3 more days of the IV medication after discharge from the LTAC. The SNF had provided her with IV antibiotics in the past. Her condition at the time of discharge was described as stable with disposition to a SNF. Discharge instructions read in part: to be followed by the facility physician, Oxygen at 2 liters via nasal cannula, Lasix 40 milligrams (mg) by mouth twice a day, Meropenem (an antibiotic) 1 gram IV twice a day for 3 days for treatment of a urinary tract infection, and ammonia levels to be monitored. A narrative note by the Case Manager dated 9/13/19 at 12:43pm indicated the discharge disposition would be back to prior Skilled Nursing Facility (SNF) with an anticipated transition date of 9/24/19. Review of a narrative note by the Case Manager dated 9/16/19 at 3:00pm revealed a clinical update was faxed to the facility and per the facility's admissions coordinator, they could no longer meet the patients needs. The family was informed and provided a list of Skilled Nursing Facilities. A Case Manager note dated 9/18/19 at 11:27am indicated the resident was alert and verbal with behaviors of constantly calling out. The goals of care were to complete antibiotic for infection, exhibit optimal respiratory function within the limits of her disease and maintain nutrition. The discharge disposition was	F 626	Records Clerk, will meet weekly to discuss findings of on-going audits and corrective actions for 6 months from the date of alleged compliance to ensure deficient practice does not recur. The Administrator will be responsible for ensuring compliance with the above-mentioned plan of correction elements. The above-mentioned audits and monitoring efforts will be coordinated through the facility Quality Assurance process. The Administrator will report findings and adjustments of audits to ensure compliance at the quarterly Executive QA meetings for the duration of the audits. The next QA meeting is scheduled January 21, 2020.	

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SNF with anticipated transition date of 9/25/19. On 9/25/19 at 12:29pm a Case Manager narrative read the discharge was cancelled due to the need for a PASRR evaluation (a Preadmission Screening and Resident Review is a federal requirement to help ensure individuals are not inappropriately placed) and would be discharged to another SNF on 9/26/19.

On 10/23/19 at 12:50pm an interview occurred with Nurse #2. She indicated the facility was able to provide care and services to Resident #1, but the resident had daily episodes of anxiety and yelling out when she was alone in her room as well as the resident's family had been noncompliant with medication aspects of the resident's care.

An interview was conducted on 10/23/19 at 1:07pm with Resident #1's responsible party (RP). He stated he had called the facility about two weeks after the resident had gone to the hospital and spoke with the Social Worker to inquire about a bed hold since he knew it could be a few more weeks until Resident #1 was ready to come back and was told "No. That's not an option" and just expected the resident would have been readmitted to the facility as before. The RP further stated he had met with the Administrator on 9/16/19 and was told the facility was not readmitting the resident due to her continued behaviors and the family's resistance to medication management. He admitted the family was cautious about medications since Resident #1 had liver disease and had tried many when she was still living at home with negative side effects. The RP further stated he felt the facility psych Nurse Practitioner (NP) was working towards finding a good balance for Resident #1's

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anxiety and his was receptive to her recommendations.

On 10/23/19 at 2:45pm an interview was held with the Administrator. He stated typically when a resident was discharged to the hospital, the physician and family are made aware, a packet of information about the resident with bed hold information was sent out with the resident, a staff member followed up with the hospital to clarify if the resident was going to be admitted and the resident's family is contacted the following day to discuss bed hold. He further stated the RP called the facility about 2 weeks after the resident was hospitalized inquiring about a bed hold, but felt it was "unethical" to take the bed hold money when we felt we could not longer manage her. He added that due to her continued behaviors, the danger of her self-inflicted fall, disrupting other residents and staff when she was anxious and family resistance to medication management the facility could no longer meet her needs.

An interview occurred with the Social Worker on 10/23/19 at 3:33pm. She was able to recall speaking with the responsible party when he called about two weeks after the resident was transferred to the hospital and his inquiry regarding a bed hold. She stated she discussed it with the Administrator and relayed that a bed hold was not possible.

On 10/23/19 at 3:50pm an interview was conducted with the Director of Admissions. She explained that she had started working at the facility at the beginning of August 2019 and did not have any conversations related to Resident #1. She stated typically information about bed hold was sent out with the resident when they

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were transferred to the ER and she followed up with the responsible party to discuss bed hold the next business day. She further stated no documentation occurred or paperwork obtained when she discussed bed holds.

An interview occurred with the Clinical Specialist from the nursing home on 10/23/19 at 4:01pm. She recalled looking at the clinical information from the LTAC Hospital and the resident was refusing to wear the Bilevel Positive Airway Pressure Machine (BiPAP-a non-invasive therapy for people suffering from sleep apnea) but she had refused to wear one at the facility as well, but her behaviors continued and was being followed by psychiatry at the LTAC. She confirmed the resident was seen by a Psychiatric Nurse Practitioner while a resident in the facility. She stated the facility was able to provide care and services to Resident #1, but since she was still exhibiting behavioral issues and due to the family noncompliance with medication management the facility felt they could no longer meet her needs. She was able to acknowledge the resident had not been placed in a nursing home with special features to provide care to the resident.

On 10/24/19 at 8:20am an interview was conducted with the Administrator and Chief Operations Officer. The Administrator stated Resident #1 did not receive a 30-day discharge notice. They both stated the facility felt Resident #1 was not stable enough for readmission due to her multiple behavioral issues and the family's resistance to medication management. They further stated, Resident #1 was disruptive to the other residents when they were trying to sleep, and the staff endured constant outbursts from the family.

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F 626	Continued From page 18 A phone interview occurred with the Facility Psych NP on 10/24/19 at 11:12am. She recalled working with Resident #1 on several occasions regarding her anxiety as well as talking with the Resident's RP. She added the RP was receptive to the medication management changes they were pursuing to help with the severe anxiety and verbal outbursts but was aware of her liver disease and the caution that had to be taken regarding medications. A phone interview occurred with the Medical Director on 10/24/19 at 12:35pm. He was familiar with Resident #1 and stated she had lots of medical issues but felt the facility was managing her behaviors appropriately as she needed lots of attention as well as the family issues.	F 626		