| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345077 | A. BUILDING _____ B. WING _____ | C 10/08/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 10/07/2024 through 10/08/2024. Event ID#3NKW11 . The following intakes were investigated NC0022660 and NC00220006.<br><br>1 of the 7 complaint allegations resulted in a deficiency. | F 000 | | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§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-<br>(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;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§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 | F 625 | | 10/18/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2024

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| F 625 | Continued From page 1<br>described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:<br>Based on record review, and Responsible Party (RP) and staff interviews, the facility failed to notify the resident or Responsible Party of the facility bed hold policy for 2 of 3 residents reviewed for hospitalization (Resident #1 and Resident #2).<br><br>The findings included:<br><br>1. Resident #1 was admitted to the facility on 9/03/24.<br><br>Review of the Minimum Data Set (MDS) admission assessment dated 9/06/24 revealed Resident #1 had moderate cognitive impairment.<br><br>a. The Change in Condition report dated 9/19/24 revealed Resident #1 was transferred to the hospital for further evaluation of elevated temperature. Resident #1 was discharged from the facility on 9/19/24.<br><br>Record review of Resident #1's electronic medical record revealed there was no documentation that Resident #1 or the Responsible Party (RP) received the bed hold policy for the 9/19/24 discharge.<br><br>The nursing progress note dated 9/22/24 revealed Resident #1 was readmitted to the facility.<br><br>b. The Change in Condition report dated 9/26/24 revealed Resident #1 was transferred to the hospital for further evaluation of temperature and hand swelling. Resident #1 was discharged from | F 625 | 1. Resident #1 was discharged to the hospital on 9/26/24 and did not return to Center. Director of Admissions left a voicemail with Resident #1 Resident Representative on 9/26/24, however, no follow up call was done to offer the bed hold for Resident # 1. Resident #2 is currently residing in the Center completing her usual activities of daily living. Resident #2 Resident Representative was called to be informed on Bed Hold Policy by the Director of Nursing on 10/15/24.<br><br>2. An audit was completed by Director of Nursing (DON)/Designee on 10/14/24 on residents transferred within the prior 7 days. Any areas of needed improvement related to written bed hold notification were corrected. Additionally, a review was completed on 10/15/24 by the administrator for any remaining residents in the hospital to ensure they had been notified of bed hold, all had been notified verbally by admission and the center sent written notice via mail on 10/16/24.<br><br>3. Education was provided by DON/Designee to nurses regarding written bed hold notification to be sent and documented on during transfer. Licensed nurses completed Post Education Test to validate understanding. Education was provided by Nursing Home Administrator (NHA) to Clinical Management regarding transferred resident□s charts to be reviewed in Clinical Morning Meeting to | |

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| F 625 | Continued From page 2<br>the facility on 9/26/24.<br><br>Record review of Resident #1's electronic medical record revealed there was no documentation that the bed hold notice was completed for Resident #1 or that Resident #1's RP was provided with the bed hold notice for the 9/26/24 discharge from the facility.<br><br>A telephone interview was conducted with Resident #1's RP on 10/07/24 at 3:36 pm who revealed she was not contacted by the Admission Director to discuss the process of the bed hold policy for the 9/19/24 or 9/26/24 discharges. The RP stated when Resident #1 returned to the facility on 9/22/24 from the 9/19/24 discharge, Resident #1 returned to the same room and all her personal belongings were still in the room. Resident #1's RP stated when she went to the facility on 9/29/24 to pick up Resident #1's clothing to wash, another resident was in the room and Resident #1's personal belongings were packed up and put in a storage closet. The RP stated she was not notified by the facility or the Admission Director that she was required to hold the room while Resident #1 was hospitalized and that Resident #1's personal belongings would be removed if she did not hold the room.<br><br>An interview was conducted on 10/07/24 at 2:30 pm with Nurse #4 who confirmed she was assigned to Resident #1 on 9/19/24 and 9/26/24 when Resident #1 was discharged to the hospital. Nurse #4 stated when a resident was sent to the hospital she would send the resident face sheet (resident information sheet) and the medication summary report. Nurse #4 stated she was not sure about the bed hold notice being sent to the hospital, but she stated she did not discuss | F 625 | ensure proper written notification is provided and documented as required. Education was provided by NHA to the Admissions Director, Admissions Coordinator, and the Business Office Manger on following up on bed hold and documenting in the Electronic Medical Record. Education will be completed by 10/17/24.<br>Newly hired Licensed Nurses, Admissions Director/Coordinator, and Business Office Manager will be educated during Department Orientation by the Staff Development Coordinator/Designee.<br>NHA/Designee to audit the completion of written bed hold notification 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks.<br><br>4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.<br><br>5. Person Responsible: Administrator<br><br>Date of Compliance 10/18/2024 | |

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holding a bed with residents before going to the hospital. Nurse #4 stated she did not know if she completed and sent a bed hold notice with Resident #1 when she discharged to the hospital on 9/19/24 or 9/24/24.

During an interview on 10/07/24 at 3:46 pm the Business Office Manager stated she was not responsible to notify the resident or the RP regarding the bed hold policy. The Business Office Manager stated the Admissions Director was responsible to contact the resident or RP to ask if they wanted to hold the bed while the resident was in the hospital and if the resident or RP decided to hold the bed then she would then reach out to discuss the costs. The Business Office Manager stated she was not asked to contact Resident #1's RP to discuss the costs for bed hold for either discharge.

An interview was conducted on 10/07/24 at 3:52 pm with the Admission Director who revealed she was responsible to contact the resident or RP regarding the bed hold policy. The Admission Director stated typically she would call the first listed RP the next morning after discharge to the hospital to see if they wanted to hold the bed while the resident was in the hospital, but she stated it was "hit or miss" that she called. The Admission Director stated she tried to call Resident #1's RP the day after the discharges but she did not speak to the RP, and she reported she did not make any further attempts to contact Resident #1's RP to discuss the bed hold policy.

During an interview with the Director of Nursing (DON) on 10/08/24 at 2:05 pm she revealed Nurse #4 was responsible to complete the bed hold notice in the electronic record and send with

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Resident #1 to the hospital, but she did not know the process once the resident was at the hospital. The DON stated all nurses were educated on the bed hold notice process, but it was not something she monitored when the discharges to hospital were reviewed.

An interview was conducted with the Administrator on 10/08/24 at 10:00 am who reported the nurse that sent the resident to the hospital was responsible to complete the bed hold notice in the electronic record and send the document to the hospital with the resident information to be given to the RP when they arrived at the hospital. The Administrator stated she did not know who was expected to give the bed hold notice to the RP at the hospital or how the facility was sure the bed hold notice was given to the RP, but stated the bed hold notice was sent with the resident paperwork at time of transfer. The Administrator stated the Admission Director was responsible to follow-up with the resident or RP when discharged to hospital to determine if the bed hold was wanted or not. The Administrator stated she was unable to locate any documentation that the bed hold notice was completed and sent with Resident #1 or that Admission Director contacted Resident #1's RP for the 9/19/24 or 9/26/24 discharges to discuss the bed hold process or if the RP wanted to hold the bed for Resident #1.

2. Resident #2 was admitted to the facility on 5/4/18.

The Minimum Data Set (MDS) quarterly assessment dated 8/23/24 revealed Resident #2 had severe cognitive impairment.

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Review of the Change in Condition report dated 9/27/24 completed by Nurse #2, revealed Resident #2 was transferred to the hospital for further evaluation of injury to the right lower leg. Resident #2 was discharged from the facility on 9/27/24.

An attempt to interview Resident #2's Responsible Party (RP) on 10/08/24 at 12:30 pm was unsuccessful.

Record review of Resident #2's electronic medical record revealed there was no documentation that the bed hold notice was completed or that Resident #2's RP received the bed hold notice for the 9/27/24 discharge from the facility.

An attempt to interview Nurse #2 on 10/7/24 at 2:00 pm and 3:15 pm were unsuccessful.

An interview was conducted on 10/08/24 at 10:52 am with the Admission Director who revealed she was not aware she needed to discuss the bed hold notice for long term care residents when they discharged to the hospital, and it was not something she had done in the past for long term care residents in the facility. The Admission Director stated she did not contact Resident #2's RP regarding the bed hold notice and desire to hold the room because she knew Resident #2 would be returning to the facility and a bed would be available at the facility when Resident #2 was ready to return.

An interview was conducted with the Administrator on 10/08/24 at 10:00 am who reported the nurse that sent the resident to the hospital was responsible to complete the bed

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| F 625 | Continued From page 6<br>hold notice in the electronic record and send the document to the hospital with the resident information to be given to the RP when they arrived at the hospital. The Administrator stated the Admission Director was responsible to follow-up with the RP when Resident #2 was discharged to hospital to determine if the bed hold was wanted or not. The Administrator stated she was unable to locate any documentation that the bed hold notice was completed for Resident #2 or that Admission Director contacted Resident #2's RP for the 9/27/24 discharge to discuss if a bed hold was wanted. | F 625 | | |