MAR 16 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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
F 203 SS=G	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for	F 203	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident number 3 no longer resides at the facility. 2. Any resident being presented with a 30-day discharge letter has the potential to be impacted by this deficient practice. 3. The facility has revised its protocol for issuing a 30-day letter to ensure DMA Form 9050, "Nursing Home Notice of Transfer/Discharge" has been completely and correctly filled out. The Business Office Manager will complete the DMA Form 9050 and will be checked for completeness and accuracy by the Administrator. The original DMA Form 9050 will be presented to the resident, along with DMA Form 9051, "Nursing Home Hearing Request Form." Copies of the above will also be mailed to the responsible party/family member via USPS certified mail. The district Director of Clinical Operations will in-service the Administrator, Social Worker, and Director of Nursing, on this revised process on March 12, 2012.	F 203 3/16/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	9 March 2012

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 203	Continued From page 1 nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide a notice of discharge to a family member and failed to document for 1 of 3 discharged residents (Resident # 3). Resident # 3 was admitted on 3/9/11 for rehabilitation services. Diagnoses included history of meningioma resection, brain neoplasm, parapelegia, chronic airway obstruction, hypertension and seizure disorder. Review of the Quarterly Minimum Data Set (MDS) dated 8/24/11 revealed the resident was cognitively intact and required extensive assistance of 1 person for bed mobility, transfers toileting and bathing. Review of the Nursing Home Notice of Transfer/Discharge dated 10/24/11 read, in part: the date of transfer/discharge hand written on the notice was 11/23/11; the reason for the notice was hand written as " you have failed after	F 203	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Using an audit tool, the facility Social Worker will review 100% of completed 30-day discharge letters for at least six months, or until six letters have been reviewed if this review number is not achieved within six months, and will present her findings monthly to the facility Performance Improvement Committee, then thereafter at a frequency determined by the PI Committee. The administrator retains overall responsibility for supervision and implementation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 203	Continued From page 2 reasonable and appropriate notice to pay for your stay at this facility " . The section where anyone else who was notified would be listed was left blank, indicating the Responsible Party or other family members were not notified of the impending transfer/discharge. " The discharge location was listed as another facility. Review of the Medical Record from 10/6/11 - 11/23/11 revealed no notation regarding the resident or having received the " Notice of Transfer/Discharge " or of being aware of an impending discharge transfer to another facility or to home. There was also no documentation regarding discharge planning or whether the RP had been informed of the impending transfer/discharge to another facility or to home. Review of the Nursing Notes from 10/6/11 - 11/23/11 did reveal that the RP was consistently informed of changes in condition. Review of Resident #3 ' s care plan revealed she was care planned for Nutrition Risk and it was last updated on 11/16/11. There were no discharge plans or other care plan items noted on the medical record. The Nursing Note dated 11/23/11 at 1800 read " Resident alert and verbal. Order to D/C home. Meds (medications) discussed with resident and son. Meds sent home (with) resident. (Name of Medical Supply company) called concerning O2 (oxygen), reported that resident has concentrator at home. Also RT (Respiratory Therapy) will see resident tomorrow in AM. Resident left facility accompanied by (RP and another family member). O2 tank from facility (with) resident. (RP) will return? "	F 203		

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F 203	Continued From page 3 During an interview with the Administrator on 2/17/12 at 3:10 PM, he stated that Resident #3 was discharged for non-payment and that he had spoken to her about it but she refused to pay her bill. He said that the 30 day discharge notice listed another facility as the discharge location but then it was changed because Resident #3 did not want to go there, she wanted to go home. When he was asked if the other facility had agreed to admit Resident #3 he indicated they had, as when Resident #3 was first discharged from the hospital, the other facility had also made a bed offer for her. Interview with the Social Worker on 2/17/12 at 3:15 PM revealed that Resident #3 was sent a 30 day discharge notice from the facility for non payment and that the discharge location was home to her son ' s apartment. She stated that she arranged for a high back w/c to be delivered to the home. She added that Resident #3 was discharged home with a facility w/c and a facility portable oxygen tank to use until the ordered medical equipment arrived. The Social Worker stated she also arranged for home care services and faxed the referral on the date of discharge which was 11/23/11. She said she spoke to Resident #3 about discharge home a couple of days before she went as she did not want to go to another facility. She also reported that she tried to talk to the RP about how Social Security works as he thought Medicaid paid everything, but he still did not want to use her checks to pay the bill. The Social Worker was asked to provide any notes she had regarding these conversations as they were not documented in the medical record but documentation was not available.	F 203		

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F 203	Continued From page 4 On 2/17/12 at 3:35 PM the Social Worker and Business Office manager provided a copy of the 30 day discharge notice (Nursing Home Notice of Transfer Discharge). The discharge location was not listed as home it was another facility. Telephone interview with a family member (Family #1) of Resident #3, on 3/2/12 at 11:37 AM, revealed that she had come to the home of the RP to visit over Thanks Giving. She stated that the family was under the impression that the resident was just leaving the facility for a visit over the Thanks Giving weekend and then returning to the facility. On 2/17/12 at 5:15 PM a telephone interview with Resident # 3 revealed she remembered the Social Worker telling quite some time her before discharge that she would be eligible for 3 hours a week of home care and when Resident #3 asked what she needed home care for, the Social Worker said because you ' re having problems with money and you need to pay if you ' re going to stay here. Resident #3 denied ever being told she was going to be discharged to another nursing home and denied ever receiving any paperwork regarding discharge. She did recall being given the bill with the amount of money she owed. She stated that on the day she was discharged she had told the Administrator that she wanted to go home for Thanks Giving and was going to come back after and he told her that she was going on the 26th anyway, so if she went she couldn ' t come back. Resident #3 stated that the Administrator said she needed to pay $6,000 or she had to leave. She said that she asked him if there was anywhere else she could go because she wasn ' t well enough to be	F 203		

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F 203	Continued From page 5 discharged and that his reply was that he didn ' t think anyone else would take her. Resident #3 stated that the day of discharge was the first time day she became aware that she was being discharged from the facility. She also said that her son was told that day that he would have to pay $1,000 and something for Resident #3 to be able to stay, which she said was different from what she was told. She did not believe anyone have spoken with the RP prior to 11/23/11 regarding being discharged home. Several attempts were made to interview the RP but he could not be reached for interview.	F 203		
F 204 SS=G	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to develop a discharge plan and failed to ensure home care could meet the needs of the resident prior to discharge for 1 of 3 discharged residents (Resident # 3). Resident # 3 was admitted on 3/9/11 for rehabilitation services. Diagnoses included history meningioma resection, brain neoplasm, parapelegia, chronic airway obstruction, hypertension and seizure disorder. Review of the Quarterly Minimum Data Set (MDS) dated 8/24/11 revealed the resident was cognitively intact and required extensive	F 204		

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F 204	Continued From page 6 assistance of 1 person for bed mobility, transfers toileting and bathing. She required limited assistance with a one person physical assist for walking and for personal hygiene and could eat independently with set up help. The MDS also indicated that Resident #3 did not have steady balance during transitions or walking and was only able to stabilize with human assistance. Resident #3 had upper and lower extremity impairment on one side and used a wheelchair (w/c) and walker for mobility. She was coded on the MDS as being occasionally incontinent of bowel and bladder (B & B). The MDS also revealed Resident # 3 had been receiving chemotherapy and oxygen therapy while she was a resident of the facility. Review of the Nursing Notes from 10/6/11 - 10/10/11 revealed, in part: 10/6/11 2:30 PM - " Last day of radiation treatments. " " ADL care provided by nursing staff. " 10/9/11 7 AM - 7 PM - " Resident (up) to w/c with assistance of 1 staff. " 10/10/11 9:30 PM - " Resident had forgotten that medication was given to her earlier. " 10/10/11 11 Pm - " assisted with PM care by two (NAs). " Review of the Psychiatric Evaluation dated 10/10/11 revealed " staff reports VH (visual hallucinations " and paranoia. Pt endorses VH at night. (?) 2° (secondary) to brain tumor/ sx (symptoms)/radiation. No recent labs (laboratory	F 204	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident number 3 no longer resides at the facility. 2. All residents being discharged back into the community have the potential to be impacted by this deficient practice. 3. The facility has revised its protocol for discharge planning to include a discharge tracking tool which will be maintained by the Social Worker (SW), or if assigned, the RN Case Manager, as each makes arrangements for post discharge care, services and equipment. In addition, the SW has been re-educated regarding charting requirements and will now record details of contact with residents, responsible parties and families; discharge planning/preparation and arrangements as they are finalized; goal changes, and destination comments, in the resident's clinical record. The discharge packet now includes the contact information and details of services and equipment that have been arranged. At the time of discharge, residents/responsible	F 204 3/16/2012

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F 204	Continued From page 7 results). " Under mental status the items checked included: unfocused, drowsy, orientation to place/person (time was not checked), slow speech, constricted and sad affect, tangential thought process, visual hallucinations, and paranoid. On a scale of unable to participate, poor, fair and good Resident #3 was checked off as fair for all of the following: short term memory, long term memory, concentration, insight and judgment. The recommendations of the evaluation included adding Risperdal 0.5 mg (milligrams twice a day and the diagnostic code identified was 298.9 (unspecified psychosis). 10/17/11 12:40 PM - " Resident had a seizure while eating lunch in the day room. Brought back to room in geri-chair. Seizure was over in a few seconds. " 10/19/11 3:15 PM - " ADLs per staff. " 10/19/11 10 PM - " Resident is a total assist. " 10/21/11 6:15 AM - ' Pt (patient) total care with ADLs. " 10/23/11 7:15 AM - " ADLs care provided per staff. Incontinent of B & B. " 10/23/11 10 PM - " Up in w/c much of the day. Alert with periods of confusion. " Review of the Nursing Home Notice of Transfer/Discharge dated 10/24/11 read, in part: the date of transfer/discharge hand written on the notice was 11/23/11; the reason for the notice was hand written as " you have failed after reasonable and appropriate notice to pay for your	F 204	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* parties will be instructed to contact the SW if any of the services do not arrive as arranged or, for some reason, are not meeting the former resident's needs. The district Director of Clinical Operations will in-service the Administrator, Social Worker, Director of Nursing, Assistant Director of Nursing, and the RN Case Manager on the revised discharge planning process on March 12, 2012. In accordance with company policy, the SW will make contact with the former resident or responsible party within seven days to assure arrangements have been provided as arranged. This communication will be maintained as a final entry on the discharge planning tool.	

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F 204	Continued From page 8 stay at this facility " . The section where anyone else who was notified would be listed was left blank, indicating the Responsible Party or other family members were not notified of the impending transfer/discharge. " The discharge location was listed as another facility. Further review of the Medical Record Nursing revealed no notation regarding the resident having received the " Notice of Transfer/Discharge " or of being aware of an impending discharge transfer to another facility or to home. There was also no documentation regarding whether the RP had been informed of the impending transfer/discharge to another facility or to home. Review of the Nursing Notes did reveal that the RP was consistently informed of changes in condition. Review of the Nursing Notes from 10/24/11 - 10/31/11 also revealed , in part: 10/26/11 - " Resident incontinent of B & B. Assisted with ADL ' s total assist. " 10/27/11 - " CNAs (Nursing Assistants NAs) in feeding pt. " Review of the Quarterly Minimum Data Set (MDS) dated 11/14/11 revealed the resident was cognitively intact and her functional status and level of assistance required to complete activities of daily living (ADLs) had not changed since the 8/24/11 review. Resident #3 was only able to stabilize while walking or during transitions with human assistance and had upper and lower extremity impairment on one side. She was coded on the MDS as being occasionally	F 204	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. The Administrator will review 100% of completed discharge planning tools for 90 days, will document his findings/approval directly on each discharge planning tool, and will present his findings monthly to the facility Performance Improvement Committee, then thereafter at a frequency determined by the committee. The administrator retains overall responsibility for supervision and implementation.	

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F 204	Continued From page 9 incontinent of bowel and bladder. The MDS also revealed Resident # 3 had been receiving chemotherapy and oxygen therapy while she was a resident of the facility. Review of Resident #3 ' s care plan revealed she was care planned for Nutrition Risk and it was last updated on 11/16/11. Under " Resident at risk for nutritional decline related to " the contributing factors checked off included: " variable intakes of food/beverages " , " restrictive or mechanically altered diet " , and " decreased self feeding " , and " requires assistance " was hand written. There was not a care plan for discharge planning and there were no other care plan items noted on the medical record. Review of a faxed communication from the Social Worker to the attending physician dated 11/22/11 read, in part, " Resident to D/C (discharge) home (with) home health. " " Medications need to be called into (name and of pharmacy). " The home health services and equipment needed were listed. On an attached page under Homebound Status it read: " considerable and taxing effort to leave home cognitive impairments mobility problems. " It was signed in the physician signature section and dated 11/23/11. The Nursing Note dated 11/23/11 at 1800 read " Resident alert and verbal. Order to D/C home. Meds (medications) discussed with resident and son. Meds sent home (with) resident. (Name of Medical Supply company) called concerning O2 (oxygen), reported that resident has concentrator at home. Also RT (Respiratory Therapy) will see	F 204		

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F 204	Continued From page 10 resident tomorrow in AM. Resident left facility accompanied by (RP and another family member). O2 tank from facility (with) resident. (RP) will return? " Review of the Occupational Therapy Discharge Summary dated 11/24/11 indicated that Resident #3 was discharged to a private residence. It also revealed, in part, that Resident #3 made progress with alertness and orientation but required maximum to moderate assistance with all activities of daily living as well as verbal cues to attend to task. One comment read: " Pt does require 24 hour assist (secondary) L hemi (left hemiparesis) and (decreased) safety. Pt was continuing to make progress with ADLSs. " The discharge recommendations included: Home Health: OT (occupational therapy)/PT (physical therapy)/Nurse/NA Adaptive Equipment: 3 in 1 commode, bathroom grab bars, long handled shower head, reacher, sock aide, long handled shoe horn, long handled sponge Assistance with: cleaning, laundry, cooking, grocery shopping, transportation and medication routine. The discharge summary indicated that a home environmental survey was not completed as this item was not checked off. Review of the Home Care provider ' s Referral Form dated 11/23/11 revealed that the D/C from the facility date was written as 11/23/11 and the SOC (start of service date for Home Care services was written 11/28/11. Under additional comments the following was hand written: " Informed (name of Social Worker at facility) we need H & P (History and Physical) on pt. Also	F 204		

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KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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
F 204	Continued From page 11 informed her pts home # disconnected. " Review of the Interdisciplinary Discharge Summary dated 11/29/11 indicated the resident was discharged home in stable condition with home health nursing, PT, OT and medications at her request. Under discharge potential it read, in part, " ST (short term) D/C home. " In the Activities section it read, in part, " confusion present, unable to recall actual facts and events. " Review of the Home Care provider ' s Case Communication form dated 11/28/11 revealed " Multiple failed attempts to reach pt # (number) disconnected. NKO (no new number) listed. SN (staff nurse) drove by and (no) # listed for apartment #. 8 males standing around in yard. (Not) safe environment to stop. (Illegible) made aware. " Review of the Home Care provider ' s Case Communication form dated 11/29/11 revealed " SN (Staff Nurse) went to patient home to set-up home health services; explained in detail to family the services provided; also explained that patient needed around the clock care; SN took patient VS (vital signs) 102 - 100 - 36 12/20; patient filled of congestion. SN called EMS to have patient to be evaluated by MD (Medical Doctor). SN also explained to family if they could not provide around the clock care for patient; that the patient does not need to come back home until they get everything in place like it should be for patient; patient admitted to hospital. " The Home Care Provider ' s Comprehensive Adult Assessment form dated 11/29/11 revealed Resident #3 was not admitted to home care but	F 204		

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F 204	Continued From page 12 was sent to hospital. There was also a hand written note stating Resident #3 had not eaten for two days and had diarrhea. Review of the Hospital History and Physical revealed Resident #3 was sent to the Emergency Care Center for evaluation of shortness of breath, wheezing and fever. A chest x-ray showed left lower lobe pneumonia and she was admitted to the hospital for treatment. Interview with Nurse #1 on 2/17/12 at 1:20 PM revealed that Resident #3 was getting better at one point and it seemed like she didn ' t need Nursing Home placement anymore, but then she got worse and needed feeding assistance. Nurse #1 indicated that at one point Resident #3 was discharged home. She stated that she was not aware of any discharge plans that had been put in place for the resident and that on 11/23/11 Resident #3 had left on first shift, so she was already gone when Nurse #1 came to work. She added that she was at the facility during second shift when the RP arrived to pick up the resident ' s belongings but she did not speak with him. On 2/17/12 at 2:00 PM Regional Staff Member #1 indicated that the Nurse who was assigned to Resident #3 at the time of discharge, and who completed discharge, no longer worked at the facility and was not available for interview. During an interview with the Administrator on 2/17/12 at 3:10 PM, he stated that Resident #3 was discharged for non-payment and that he had spoken to her about it but she refused to pay her bill. He said that the 30 day discharge notice listed another facility as the discharge location but	F 204		

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F 204	Continued From page 13 then it was changed because Resident #3 did not want to go there, she wanted to go home. When he was asked if the other facility had agreed to admit Resident #3 he indicated they had, as when Resident #3 was first discharged from the hospital, the other facility had also made a bed offer for her. Interview with the Social Worker on 2/17/12 at 3:15 PM revealed that Resident #3 was sent a 30 day discharge notice from the facility for non payment and that the discharge location was home to her son ' s apartment. She stated that she arranged for a high back w/c to be delivered to the home. She added that Resident #3 was discharged home with a facility w/c and a facility portable oxygen tank to use until the ordered medical equipment arrived. The Social Worker stated she also arranged for home care services and faxed the referral on the date of discharge which was 11/23/11. She said she spoke to Resident #3 about discharge home a couple of days before she went as she did not want to go to another facility. When asked if she had confirmation back from the Home Care provider that services could be arranged on short notice over the Thanks Giving holiday and weekend, she stated that if they couldn ' t she should have heard back from them. She then said that she did know that the medical equipment had arrived on the day of discharge. She also reported that she tried to talk to the RP about how Social Security works as he thought Medicaid paid everything, but he still did not want to use her checks to pay the bill. The Social Worker was asked to provide any notes she had regarding these conversations as they were not documented in the medical record but	F 204		

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F 204	Continued From page 14 documentation was not available. On 2/17/12 at 3:35 PM the Social Worker and Business Office manager provided a copy of the 30 day discharge notice (Nursing Home Notice of Transfer Discharge). The discharge location was not listed as home it was another facility. On 2/17/12 at 3:45 PM telephone interview with a staff member of the Home Care Company (Home Care #1) revealed that they received the referral on 11/23/11 and the start of service date was listed as 11/28/11. He stated that the documentation they had indicated that on 11/28/11 the visit was not done as the phone was disconnected, the number to identify which home was the correct one was not visible, and the location appeared unsafe to go searching alone. Home Care #1 said that according to her notes, when the Nurse went to do the assessment on 11/29/11 Resident #3 was not admitted to Home Care as she was not safe to be at home, she had a temperature and had not eaten for two days. He added that Resident #3 needed around the clock care and was sent to the hospital and admitted. Telephone interview with a family member (Family #1) of Resident #3, on 3/2/12 at 11:37 AM, revealed that she had come to the home of the RP to visit over Thanks Giving. She stated that the family was under the impression that the resident was just leaving the facility for a visit over the Thanks Giving weekend and then returning to the facility. Family #1 stated she and Family #2 (not the RP) went to pick up the resident for the visit but when they got there, all of Resident #3 ' s belongings were packed. Family # 1 stated they	F 204		

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F 204	Continued From page 15 asked Resident #3 why all her things were packed and Resident #3 said that they were putting her out of the Nursing Home because she had not paid her bill. Family #1 said that another family member was handling the resident ' s Social Security check and the resident wasn ' t capable of sorting it out herself due to her condition. Family #1 also said that they were told that home care would be coming out on Monday (11/28/11) but then added that no one showed up on Monday. Telephone interview with the Home Care provider staff member who received the referral from the facility (Home Care #2), on 3/2/12 at 11:42, that she received the faxed referral just before 1:40 PM on 11/23/11. She stated that every morning she receives a staffing report and that the report that morning showed that there was no staff available to provide services over the Thanks Giving holiday or weekend, so services could not start until 11/28/11. She stated that whenever she gets a referral she tries to reach the patient and family to let them know when services will start and what to expect. She stated that she was unable to reach Resident #3 as the phone was disconnected. She said she also lets the facility know up front when services can start and that she told the facility Social Worker on the telephone that the earliest available start of service date was 11/28/11 and that if another start date was required she should send the referral to another agency. Home Care #2 stated that the Social Worker indicated that start of service date of 11/28/11 was acceptable. In second telephone interview with Family #1 on 3/2/12 at 11:47 AM she added that the Nursing	F 204		

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F 204	Continued From page 16	F 204		

Home did not give the Resident a chance to pay her bill and " all the Social Worker had to do was have her Social Security check pulled like the other Nursing Home did. We would have let her do that. " Family #1 said that she did not believe the RP was aware that the resident was being discharged home or that there had been a plan to discharge her to another Nursing Home facility. She did say that he had been told that they were going to send her to a psychiatric facility at one time. She also stated that the RP lived in the home but was not there 24 hours a day and Resident #3 was to sick to be discharged from the facility as she was not talking, moving around or eating while at home.

On 2/17/12 at 5:15 PM a telephone interview with Resident # 3 revealed that she recalled talking with someone early in her stay at the facility and telling them she could not use her Social Security check to pay her bills at the facility because she wanted to keep her apartment so she could go back home in a year or so. She also stated that she remembered the Social Worker telling quite some time her before discharge that she would be eligible for 3 hours a week of home care and when Resident #3 asked what she needed home care for, the Social Worker said because you ' re having problems with money and you need to pay if you ' re going to stay here. Resident #3 denied ever being told she was going to be discharged to another nursing home and denied ever receiving any paperwork regarding discharge. She did recall being given the bill with the amount of money she owed. She stated that on the day she was discharged she had told the Administrator that she wanted to go home for Thanks Giving and was going to come back after, and he told

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F 204	Continued From page 17 her that she was going on the 26th anyway, so if she went she couldn ' t come back. Resident #3 stated that the Administrator said she needed to pay $6,000 or she had to leave. She said that she asked him if there was anywhere else she could go because she wasn ' t well enough to be discharged and that his reply was that he didn ' t think anyone else would take her. Resident #3 said that there were a couple of nurses and Supervisors in the room during the conversation. She said that after that her RP came to take her home (attempts to reach the RP but he could not be contacted for interview). She said that she was feeling sick that day and had diarrhea and that she continued to have diarrhea while she was at home. When questioned about what happened at home she didn ' t really remember a lot and did not recall being told about home care services on the day of discharge. Resident #3 said she was at her own apartment where she and her RP lived. She said family members told her they brought her food but she doesn ' t remember and then she ended up in the hospital with pneumonia.	F 204		