STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0403	A. BUILDING: _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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) COMPLETE DATE
D 226	10A NCAC 13F .0702(b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). This Rule is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to utilize a justified reason for discharge of 1 of 4 residents reviewed for discharge procedures. (Resident #1). Findings included: Review of a facility resident discharge policy, revised May 2007, referred to North Carolina Administrative Code 10A NCAC 13F .0702 and lists the reasons for discharge of a resident verbatim as found in the Administrative Code.	D 226	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. D226 Resident # 1 was discharged on 3/19/14. For all residents, 100% of all facility-initiated discharges will be based on one of the following reasons: (1) the	6/17/14

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

Electronically Signed | 06/09/14

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D 226	Continued From page 1 Resident #1 was an adult care home resident with diagnoses which included schizophrenic state, idiopathic neuropathy, and chronic pain syndrome. Review of Resident #1's most recent care plan dated 12/20/13 included the problem of psychosocial well-being with a target goal dated 01/24/14 to verbalize positive feelings and demonstrate coping behaviors. Review of Resident #1's medical record revealed a psychiatric mental health nurse practitioner (PMHNP) consultation dated 01/25/14. The PMHNP specified the resident was relatively stable with nursing staff voicing behavioral concerns. The PMHNP assessment noted Resident #1 would be better off in a group home but medical needs would make this difficult and recommended a follow up consultation in 4 to 8 weeks. Another psychiatrist consultation dated 02/18/14 revealed the resident was smoking again, "bumming" cigarettes from other residents and smoking cigarette butts. The psychiatrist documented staff counselling the resident on this behavior and the resident as stopping it but denying it. Medications were documented as reviewed during this consultation. Review of a controlled drug receipt/record/disposition form revealed the resident's name and the narcotic analgesic oxycodone/acetaminophen, 10 milligrams (mg)/325mg strength with instructions to take 1 tablet by mouth every 4 hours as needed (PRN) for pain. Documented on this form was a date of 03/02/14 and the statement "33 with pt [patient] LOA [leave of absence]" and with an illegible signature. Review of progress notes dated 03/02/14 revealed the resident leaving on a LOA with family with medications sent with him after narcotic verification by 2 nurses and a medication	D 226	discharge is necessary for the resident□s welfare and the resident□s needs cannot be met in the facility as documented by the physician, physician assistant, or nurse practitioner; (2) the resident□s health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident□s physician, physician assistant, or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding the reasons for the transfer/ discharge of a resident. Any staff member on leave of absence will be educated prior to beginning work. 6-6-14 An audit tool was developed to include if the proper reason was met for the initiation of the resident□s discharge. 100% of all residents being discharged will be audited for compliance with proper transfer/ discharge reasons. Audits will be completed by the Administrator weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring.	

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D 226	Continued From page 2 technician, along with a copy of a medication list, dosages and how to take them. Review of a Release of Responsibility for Leave of Absence form revealed Resident #1 signed out of the facility on 03/02/14 at 9:40 PM and signed back into the facility on 03/06/14 at 6:00 PM. Review of progress notes dated 03/07/14 revealed the resident was in no distress. Review of another progress note dated 03/10/14 revealed the resident refused to take a shower, speech was slurred, he was lethargic and slow to respond to conversation. This note documented the resident as finally agreeing to take a shower. Another progress note dated 03/11/14 revealed "new orders" were received. Another progress note dated 03/19/14 revealed the following: "discharge- discharge from ALF [assisted living facility] to [name of another facility], meds sent with resident, discharge instructions provided and no acute distress noted, belongings sent with resident." Review of a discharge plan of care form completed by the social worker (SW) revealed Resident #1 left by van, using a wheelchair, no referrals were made to home health, the medication administration record and medications were sent with him and he was to follow up with his primary care physician. Review of a facility discharge summary form dated 03/19/14 revealed a check in the box for the pre-printed statement "post discharge plan of care completed". Boxes were not checked for the pre-printed statements "physician order", "discharge plan discussed with member/family" and "other." Admitting diagnoses were hand-written in the designated block on the form but no comments were noted in the block labeled "Discharge Diagnosis." This form had	D 226	6-13-14 All audit information will be analyzed and discussed by the Administrator at the QA Committee meetings. 6-17-14	

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D 226	Continued From page 3	D 226		

handwritten notation of the "Resident transferred to [name of facility]" with disposition noted as assisted living. An illegible signature was noted on the physician signature line and dated 04/22/14.

An internal document provided by the Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 as he was "an endangerment to himself." This document noted he returned from his LOA on 03/07/14 and had taken more medication than ordered and that the SW and NHA [nursing home administrator] met with Resident #1 on 03/10/14 to discuss the concern and discuss discharge plans, asking the resident where he would like to live. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident, made a bed offer and the resident was discharged on 03/19/14.

An interview with Nurse #1 on 05/14/14 at 2:00 PM revealed her routinely assignment to the skilled nursing unit, but she was assigned to a certain number of ALF residents located on a separate unit to address medical concerns such as reviewing vital signs, assessing any resistance to care, nausea and other acute medical conditions. She stated charting on ALF residents was "by exception" and done only with changes in the ALF resident's condition. She stated the facility had a good mental health system in place with a psychiatrist available by pager if needed. She stated the facility also had a SW who interviewed residents and referred them to the psychiatrist if needed. Nurse #1 stated Resident #1 had resided in the facility for a while, he was alert and oriented and he could do for himself.

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D 226	Continued From page 4 She stated he was quiet, wanted to smoke and wanted his PRN oxycodone/acetaminophen every 4 hours. She stated the resident went on a LOA with family and returned short of his oxycodone/acetaminophen. She stated on the evening of his return from his LOA, Resident #1 did not ask for any of the oxycodone/acetaminophen. She added she checked on him and he was fine and described him as responsive and not over-sedated. She stated there was nothing punitive done toward him for the missing pain medication and the resident did not share with her a reason why he was going to another facility. Nurse #1 stated the psychiatrist was checking on him, adjusting medications and the resident received adequate mental health services. She stated the resident could also have been seen by the nurse practitioner, if required. An interview with the SW on 05/15/15 at 10:00 AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident requested, discharge staff would be notified and a care plan meeting with an interdisciplinary team to determine safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The Social Worker stated the discharge plan of care form was completed with information such as ombudsman information and nursing staff and the resident would sign the form. She stated on this form there was no place to note the reason for discharge and the more likely place to document this would be in the progress notes. The SW	D 226		

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D 226	Continued From page 5	D 226		

stated Resident #1 was a danger to himself as he would leave the facility, take his medications with him, be gone for undetermined lengths of time and upon his return was noted to have taken more medications than what he should have. She stated there was an incident which she and a nurse investigated when the resident refused to take a shower, having an odor and lethargy, and he finally agreed to take a shower. She stated that incident was the second or third time he had done that. She stated he broke rules about smoking and would "bum" cigarettes off other residents. She stated the "last straw" was coming back from a LOA "high" and being "a danger to himself" and that when in that state they were not themselves, with the possibility of stumbling and falling on someone. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the incident. The SW continued that she was notified the following day, after Resident #1's return to the facility following his LOA, of his pending discharge due to his and other resident's safety. She stated the Director of Nursing (DON) and Administrator were notified, possibly the same day or the next morning. She stated she recalled everything happened on a Friday, so she thought her progress note was written first thing on Monday morning, 03/10/14. She stated the Director of Nursing (DON) and Administrator must have had a conversation with him, possibly on Monday 03/10/14, and they normally had conversations regarding his behavior. The SW stated she recalled the Administrator telling her to have a talk with Resident #1 and she gave him a "heads up" that he may need another place to live, at which point he became very angry. She stated it was after this conversation that the DON and Administrator told her to find a new facility for the resident and when an opening was found, the

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D 226	Continued From page 6	D 226		

facility proceeded with discharge. The SW stated Resident #1 was receiving psychiatric care for scheduled visits as well as for acute concerns. She stated the psychiatrist would address any issues regarding addiction and she was not sure if the resident received a medical referral related to the incident upon his return from his LOA.

An interview with Nurse #2 on 05/15/15 at 10:40 AM revealed the SW had asked her to go to the ALF unit to check on Resident #1 and he had a very bad odor. She stated he appeared dazed, had slurred speech and he would take a shower later. She stated he was asked to take a shower at that time, he agreed, and she said he stated it did not take 2 people to ask him this. She stated she told the NAs he agreed to take a shower and she returned to her office. She stated she may have let the SW document this interaction with Resident #1. She stated he appeared as if he was coming "out of something" but he was able to talk and answer correctly. She stated when medication technicians were asked if he took anything they replied no, but that he returned to the facility with an empty medication card of pain medications. She stated she was told of his condition after his return on the second shift and she thought she went to see him between 4:00 PM and 6:00 PM. She stated she knew he had a history of drinking and many times after returning from a LOA he would be in an inebriated state.

A phone interview with Resident #1 on 05/15/14 at 11:05 AM revealed him to be alert, oriented, cognitively intact and appropriate for an interview. He stated he was told by the Administrator and DON while in the smoking area he had no choice and must leave the facility. He stated he was not given a document notifying him of the right to

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appeal the decision to discharge and he wanted to stay as it was a brand new building, he was very comfortable and he got along with everybody. He stated he returned with right amount of morphine sulfate but was told he was short 5 or 6 of the oxycodone/acetaminophen tablets, but that was no reason to be kicked out of the facility.

An interview with Nurse #3 on 05/15/14 at 1:04 PM revealed her assignment as a "back up" nurse to the ALF unit. She stated Resident #1 was real pleasant with her and that they had a bond. She stated he was a smoker, he liked certain staff to do certain things and she had a way with him. She stated she did not know why he left the facility as it occurred on the second shift as she was coming in. She stated Resident #1 would come to her even though he might not be assigned to her.

Combined interviews with the Administrator and DON on 05/15/14 at 4:15 PM revealed ALF residents were more long term and when discharge was indicated, it was usually due to their preferences or to place them in a more appropriate setting, as it was the case for Resident #1. In cases like Resident #1's, the DON and Administrator stated the resident would be asked for their preference and when he did not state one, they found a facility who assessed him and accepted his admission. They stated the resident was aware of the transfer the whole time before he left and their approach with him was an offer due to the nature of the issues as he was "unsafe." They stated it was not a one-time occurrence, they had discussions with him on prior occasions and his transfer was not going to be an option. They stated they had medication orders to follow and thought that someday they

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would find him in an overdose situation. The DON stated she counted out the narcotic medication and figured out how many doses he needed for the time he was expected to be out of the facility. She stated the resident took all his medications and the only narcotic medication missing doses was the oxycodone/acetaminophen. They stated Resident #1 was his own responsible person and had no impaired cognition preventing him from understanding instructions. They stated a similar incident occurred in mid July 2013 that did not require hospital treatment, but they could not recall any documentation regarding the discussion they had with regarding the ramifications of the resident taking too many medications.

The DON and Administrator further revealed Resident #1 returned to the facility on the evening of 03/06/14 and it was reported to them on Friday morning 03/07/14 that nursing staff told the DON the resident had not bathed, they could not get him up and the SW went to talk to the resident with Nurse #2. They stated on Monday, 03/10/14 the SW had a discussion with Resident #1 about where he would like to go, that it was a discussion, he understood and although not happy he showed no resistance. They stated there were more conversations with Resident #1 while waiting for the accepting facility to complete their assessment. The DON stated the resident was "a danger to himself" and their decision was "subjective verses objective" as they were not sure if the resident popped the narcotic medication from the packaging to stash in his room. They stated the physician assistant did not feel comfortable managing Resident #1's medications as they did not want to be responsible for any adverse response, but they

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D 226	Continued From page 9 stated they were not sure if the PA or the staff covering for them assessed the resident. The DON and Administrator stated they did think a provider should have been called and notified. They stated the reason for discharge of a resident is made in the SW notes.	D 226		
D 227	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to provide discharge and appeal rights notices to an adult care home resident within a 30 day timeframe for 1 of 4 residents reviewed for discharge procedures. (Resident #1). Findings included: Review of a facility resident discharge policy, revised May 2007, referred to North Carolina Administrative Code 10A NCAC 13F .0702 which included providing a discharged resident state discharge forms within 30 days of notifying a resident of a pending discharge.	D 227	D227 Resident # 1 was discharged on 3/19/14. For all residents, for 100% of all facility-initiated discharges, all residents will be provided the discharge and appeal right notices within a 30 day timeframe except when the notice needs to be made as soon as practicable based on health and safety reasons. 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding the 30 day notice of discharge and appeal rights. Any staff member on leave of absence will be	6/17/14

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D 227	Continued From page 10 Resident #1 was an adult care home resident with diagnoses which included schizophrenic state, idiopathic neuropathy, and chronic pain syndrome. Review of Resident #1's most recent care plan dated 12/20/13 included the problem of psychosocial well-being with a target goal dated 01/24/14 to verbalize positive feelings and demonstrate coping behaviors. Review of progress notes dated 03/19/14 revealed the following: "discharge- discharge from ALF [assisted living facility] to [name of another facility], meds sent with resident, discharge instructions provided and no acute distress noted, belongings sent with resident." Review of a discharge plan of care form completed by the social worker (SW) revealed Resident #1 left by van, using a wheelchair, no referrals were made to home health, the medication administration record and medications were sent with him and he was to follow up with his primary care physician. Review of a facility discharge summary form dated 03/19/14 revealed a check in the box for the pre-printed statement "post discharge plan of care completed". Boxes were not checked for the pre-printed statements "physician order", "discharge plan discussed with member/family" and "other." Admitting diagnoses were hand-written in the designated block on the form but no comments were noted in the block labeled "Discharge Diagnosis." This form had handwritten notation of the "Resident transferred to [name of facility]" with disposition noted as assisted living. An illegible signature was noted on the physician signature line and dated 04/22/14. An internal document provided by the	D 227	educated prior to beginning work. 6-6-14 An audit tool was developed to include if the resident being discharged received a 30 day notice of discharge and appeal rights. 100% of all residents being discharged will be audited for compliance with proper transfer/ discharge notice. Audits will be completed by the Administrator weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. 6-13-14 All audit information will be analyzed and discussed by the Administrator at the QA Committee meetings. 6-17-14	

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D 227	Continued From page 11	D 227		

Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 after a discussion with the resident about where he would like to live. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident, made a bed offer and the resident was discharged on 03/19/14.

An interview with the SW on 05/15/15 at 10:00 AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident requested, discharge staff would be notified and a care plan meeting with an interdisciplinary team to determine safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the incident precipitating the resident's discharge. The SW stated that she was notified on 03/07/14, after Resident #1's return to the facility on 03/06/14 following his LOA, of his pending discharge. She stated she recalled the Administrator telling her to have a talk with Resident #1 and she gave him a "heads up" that he may need another place to live, at which point he became very angry. She stated it was after this conversation that the DON and Administrator told her to find a new facility for the resident and when an opening was found, the facility proceeded with discharge.

A phone interview with Resident #1 on 05/15/14

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	NH0403	A. BUILDING: _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

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D 227	Continued From page 12	D 227		

at 11:05 AM revealed him to be alert, oriented, cognitively intact and appropriate for an interview. He stated he was told by the Administrator and Director of Nursing (DON) while in the smoking area he had no choice and must leave the facility. He stated he was not given a document notifying him of the right to appeal the decision to discharge and he wanted to stay as it was a brand new building, he was very comfortable and he got along with everybody.

Combined interviews with the Administrator and DON on 05/15/14 at 4:15 PM revealed ALF residents were more long term and when discharge was indicated, it was usually due to their preferences or to place them in a more appropriate setting, as it was the case for Resident #1. In cases like Resident #1 ' s, the DON and Administrator stated the resident would be asked for their preference and when he did not state one, they found a facility who assessed him and accepted his admission. They stated the resident was aware of the transfer the whole time before he left and their approach with him was an offer due to the nature of the discharge, but his transfer was not going to be an option. They stated Resident #1 was his own responsible person and had no impaired cognition preventing him from understanding instructions. The DON and Administrator further revealed that on Monday, 03/10/14 the SW had a discussion with Resident #1 about where he would like to go, that it was a discussion, he understood and although not happy he showed no resistance. They stated there were more conversations with Resident #1 while waiting for the accepting facility to complete their assessment. They stated the reason for discharge of a resident is made in the SW notes. When shown a copy of the NC Administrative Code stating residents were to be given 30 days

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D 227	Continued From page 13 for discharge notice, they stated Resident #1 did not receive 30 day notice.	D 227		
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule: (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to document in the record of an adult care home resident the reason for discharge for 1 of 4 reviewed for discharge procedures. (Resident #1). Findings included:	D 228	D228 Resident # 1 was discharged on 3/19/14. For all residents, for 100% of all facility-initiated discharges, the reason for discharge will be documented in the record of the adult care home resident. Documentation will be completed by the	6/17/14

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D 228	Continued From page 14 Review of a facility resident discharge policy, revised May 2007, referred to North Carolina Administrative Code 10A NCAC 13F .0702 which included documentation of a reason for discharge in the medical record. Resident #1 was an adult care home resident with diagnoses which included schizophrenic state, idiopathic neuropathy, and chronic pain syndrome. Review of a facility discharge summary form dated 03/19/14 revealed a check in the box for the pre-printed statement "post discharge plan of care completed". Boxes were not checked for the pre-printed statements "physician order", "discharge plan discussed with member/family" and "other " Admitting diagnoses were hand-written in the designated block on the form but no comments were noted in the block labeled "Discharge Diagnosis." This form had handwritten notation of the "Resident transferred to [name of facility]" with disposition noted as assisted living. An illegible signature was noted on the physician signature line and dated 04/22/14. Combined interviews was conducted with the Administrator and Director of Nursing on 05/15/14 at 4:15 PM. They stated the reason for discharge of a resident was made in the SW notes and they were not aware of a reason for discharge missing from the resident's record.	D 228	physician, physician assistant, or nurse practitioner. Documentation will include the condition or circumstance that endangers the health of safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility□s action taken to address the problem prior to pursuing discharge of the resident. It will include written notices of warning of discharge for the failure to pay the costs of services and accommodations and will include the specific health need or condition of the resident that the facility determined could not be met in the facility. 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding the required documentation of the reasons for the discharge. Any staff member on leave of absence will be educated prior to beginning work. 6-6-14 An audit tool was developed to include if the resident□s record included the required documentation for the reason of discharge. 100% of all residents being discharged will be audited for compliance with proper transfer/ discharge documentation. Audits will be completed by the Administrator weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. 6-13-14 All audit information will be analyzed and discussed by the Administrator at the QA Committee meetings. 6-17-14	

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D 229	10A NCAC 13F .0702 (e) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (e) The facility shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505. (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated. (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services. (4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.	D 229		6/17/14

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D 229	Continued From page 16 This Rule is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to provide a discharged adult care home resident discharge forms for 1 of 4 residents reviewed for discharge procedures. (Resident #1). Findings included: Review of a facility resident discharge policy, revised May 2007, refers to North Carolina Administrative Code 10A NCAC 13F .0702 which included providing a discharged resident state discharge forms. Resident #1 was an adult care home resident with diagnoses which included schizophrenic state, idiopathic neuropathy, and chronic pain syndrome. Review of Resident #1's most recent care plan dated 12/20/13 included the problem of psychosocial well-being with a target goal dated 01/24/14 to verbalize positive feelings and demonstrate coping behaviors. Review of progress notes dated 03/19/14 revealed the following: "discharge- discharge from ALF [assisted living facility] to [name of another facility], meds sent with resident, discharge instructions provided and no acute distress noted, belongings sent with resident. " Review of a discharge plan of care form completed by the social worker (SW) revealed Resident #1 left by van, using a wheelchair, no referrals were made to home health, the medication administration record and medications were sent with him and he was to follow up with his primary care physician. Review of a facility discharge summary form dated 03/19/14 revealed a check in the box for the pre-printed statement "post discharge plan of care completed". Boxes were not checked for the	D 229	D229 Resident # 1 was discharged on 3/19/14. For all residents, for 100% of all facility-initiated discharges, all residents will be provided the required discharge forms to include the Adult Care Home Notice of Discharge and the Adult Care Home Hearing Request Form and a copy maintained in the resident□s record. 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding issuing the proper discharge and appeal rights forms. Any staff member on leave of absence will be educated prior to beginning work. 6-6-14 An audit tool was developed to include if the resident being discharged received the Notice of Discharge and Hearing Request forms. 100% of all residents being discharged will be audited for compliance with proper transfer/ discharge and appeal rights forms. Audits will be completed by the Administrator weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. 6-13-14 All audit information will be analyzed and discussed by the Administrator at the QA Committee meetings. 6-17-14	

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D 229	Continued From page 17	D 229		

pre-printed statements "physician order", "discharge plan discussed with member/family" and "other." Admitting diagnoses were hand-written in the designated block on the form but no comments were noted in the block labeled "Discharge Diagnosis." This form had handwritten notation of the "Resident transferred to [name of facility]" with disposition noted as assisted living. An illegible signature was noted on the physician signature line and dated 04/22/14.

An interview with the SW on 05/15/15 at 10:00 AM revealed the discharge plan of care form was completed with information such as ombudsman information and nursing staff and the resident would sign the form. She stated on this form there was no place to note the reason for discharge and the more likely place to document this would be in the progress notes. She stated there were no others documents she provided to discharged residents other than a copy of the discharge plan of care. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the incident precipitating the resident's discharge. The SW stated that she was notified the following day, after Resident #1's return to the facility following his Leave of Absence, of his pending discharge. She stated she recalled the Administrator telling her to have a talk with Resident #1 and she gave him a "heads up" that he may need another place to live, at which point he became very angry. She stated it was after this conversation that the Director of Nursing (DON) and Administrator told her to find a new facility for the resident and when an opening was found, the facility proceeded with discharge.

A phone interview with Resident #1 on 05/15/14

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D 229	Continued From page 18	D 229		

at 11:05 AM revealed him to be alert, oriented, cognitively intact and appropriate for an interview. He stated he was told by the Administrator and DON while in the smoking area he had no choice and must leave the facility. He stated he was not given a document notifying him of the right to appeal the decision to discharge and he wanted to stay as it was a brand new building, he was very comfortable and he got along with everybody.

Combined interviews with the Administrator and DON on 05/15/14 at 4:15 PM revealed ALF residents were more long term and when discharge was indicated, it was usually due to their preferences or to place them in a more appropriate setting, as it was the case for Resident #1. In cases like Resident #1's, the DON and Administrator stated the resident would be asked for their preference and when he did not state one, they found a facility who assessed him and accepted his admission. They stated the resident was aware of the transfer the whole time before he left and their approach with him was an offer due to the nature of the discharge, but his transfer was not going to be an option. They stated Resident #1 was his own responsible person and had no impaired cognition preventing him from understanding instructions. The DON and Administrator further revealed that on Monday, 03/10/14 the SW had a discussion with Resident #1 about where he would like to go, that it was a discussion, he understood and although not happy he showed no resistance. They stated there were more conversations with Resident #1 while waiting for the accepting facility to complete their assessment. They stated the reason for discharge of a resident was made in the SW notes. When shown copies of required forms referenced in the NC Administrative Code to be

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D 229	Continued From page 19 presented to a discharged resident, they stated they did not complete these forms for Resident #1.	D 229		