DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING ______ B. WING ______	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	**969 COX ROAD GASTONIA, NC 28054**

(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 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; 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; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; 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. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, staff interviews, family interview, and physician interview, the facility failed to have a supportable reason to issue an immediate discharge for 1 of 3 sampled residents reviewed for discharges (Resident #6).	F 201	Documentation provided by physician and included in the medical record regarding supportable reason to issue immediate discharge for Resident #6. All residents identified as having the	1/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/16/2015

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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The findings included:

The facility's Transfer and Discharge Procedure, with a revised date of June 2013, stated that "A resident will not be transferred or discharged without an assessment to determine if a new plan of care would allow for the resident's needs to be met at the facility."

Resident #6 was admitted to the facility on 07/02/13. Her diagnoses included muscle weakness, bipolar disorder, mood disorder and depression. The medical record revealed she had been under the care of psychiatric services in the facility since 08/07/13 due to periods of yelling out, confusion and wandering.

She had been care planned for moods, behaviors, and psychotropic medications since 12/10/13 and falls since 03/20/14.

Review of the medical record revealed Resident #6 was seen by the facility's consultant psychiatric nurse practitioner (psych NP) on 09/10/14. These notes stated staff reported her behaviors were better since the start of Seroquel (an antipsychotic medication) on 09/04/14. Psych notes on 10/01/14 revealed Resident #6 was more hostile and guarded this date and having hallucinations. The psych NP increased the dose of Seroquel to 25 milligrams (mg) 3 times a day. On 10/08/14 the psych NP noted hallucinations had begun to stabilize. On 10/23/14, psych NP notes revealed no worsening of mood and no new behaviors. The psych NP saw the resident on 10/30/14 for recent falls, increased restlessness and anxiety. The resident was noted as yelling a lot and could not be redirected.

F 201

potential to be affected.

Audit conducted by Administrator to identify other residents given immediate discharge notice in the last 30 days to ensure supportable reason to issue immediate discharge notice.

Review regarding reasons for transfer/discharge of a resident provided by Administrator to Social Services Director, Social Services Assistant, and Director of Nursing to ensure compliance.

Discharge/Transfer Monitoring Tool implemented to ensure appropriate reasons for discharge/transfer are supported. Discharge/Transfer Monitoring Tool to be completed by Administrator for all discharges/transfers 3 times weekly for 2 weeks; then once weekly for 2 weeks; then once monthly for 3 months.

Results of Discharge/Transfer Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement Program to evaluate compliance and effectiveness monthly for 3 months.

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At this visit, the psych NP decreased Prozac (an antidepressant) to 20 mg per day due to falls and changed Clonazepam (an antianxiety medication) to 0.5 mg 2 times a day and 1 mg at hour of sleep with instructions to hold for sedation/falls. The last noted visit by the psych NP was on 11/13/14 when Resident #6 was reportedly unable to sleep at night, staying awake and yelling. He noted there was no major escalation of mood noted, her behaviors were unpredictable and she was irritable at times. He further noted she remained compliant with taking medications with no side effects reported by staff. The plan was to start Trazodone (an anti-depressant) 25 milligrams (mg) each night for insomnia.

Nursing notes for November 2014 revealed Resident #6 exhibited behaviors including talking loudly, cursing, yelling, and/or hallucinating as follows:
*11/14/14 at 11:30 PM early in the evening around 7:30 PM she yelled loudly to her son who was not in the room. She was redirected with some effect noted and she quieted after 30 minutes on her own.
*11/14/14 during the 11:00 PM to 7:00 AM shift the resident was quiet until 4:00 AM, when she yelled and argued loudly to someone who was not in the room. She became quiet at 5:30 AM.
*11/15/14 at 1 :00 PM she removed her lap belt and fell sustaining a scratch on her head.
*11/16/14 at 1:00 PM resident removing lap belt and attempting to stand.
*11/19/14 at 11:00 PM resident talking to herself at 6:30 PM and now noted to be loudly conversing to someone not in the room. She was cooperative during procedure to collect urine via in and out catheterization.

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On 11/21/14 at 9:20 AM, nursing notes revealed the family expressed concern about Resident #6 being lethargic. The nurse explained the resident was being treated for a urinary tract infection which could cause lethargy but the family insisted she be sent to the hospital. Nursing notes revealed she returned from the hospital on 11/21/14 at 1:45 PM. The nursing note stated the nurse spoke to the emergency room physician who stated the resident's altered mental status was related to her urinary tract and infection and the antibiotics would resolve that issue. The nurse practitioner was called per family request and orders were received for the discontinuation of Trazodone, to continue Clonazepam 1 mg routinely at night and to reduce the Clonazepam 0.5 mg 2 times a day routinely to 2 times a day as needed (prn).

A telephone order by the nurse practitioner dated 11/24/14 decreased the Seroquel from 12.5 mg at 6:00 AM and 25 mg at 2 pm and 10:00 PM to Seroquel 12.5 mg 3 times a day 6:00 AM, 2:00 PM and 10:00 PM per family request. The nursing note dated 11/24/14 at 11:00 AM noted the medication changes and noted the resident had been yelling, using derogatory language and saying profane things about family and others. She was medicated with the prn Clonazepam.

Nursing notes continued to document behaviors as follows:
*11/24/14 at 3:00 PM alert and talking to people who are not present in the room.
*11/28/14 at 2:00 PM resident had increased anxiety and started to yell, pull lap belt loose and threw cup of juice on the floor. Prn anxiety medication administered.
*11/29/14 during 11:00 PM to 7:00 AM shift,

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F 201	Continued From page 4 resident was quiet until approximately 3:30 AM when she began to talk loudly to self. This continued until approximately 4:00 AM and she rested the rest of the shift. *11/30/14 at 2:30 PM resident in hall yelling out and talking loudly to self. Received prn medication and was quiet by 3:00 PM. Resident #6's most recent Minimum Data Set, a quarterly dated 11/26/14, coded her with a score of 12 out of 15 on the brief interview for mental status which indicated she was cognitively intact. She required extensive assistance for most activities of daily living skills, was coded for no delirium and no behaviors, receiving psychotropic medications and having a history of falls. No changes were made to any of the care plans at this time. Nursing notes revealed ongoing behaviors, hallucinations and removing self release lap belt as follows: *12/01/14 during the 11:00 PM to 7:00 AM shift the resident was talking loudly to self at beginning of shift. At approximately 2:00 AM she quieted down and rested the rest of the shift. *12/02/14 at 8:00 PM resident opened lap belt 2 times. *12/02/14 at 11:00 PM resident removed lap belt several times during shift. *12/03/14 at 8:30 PM resident noted in bed with legs dangling over side of low bed. When asked resident if she would put legs in bed, resident began to curse and talk to other people who were not in the room. After 10 minutes staff was able to redirect. Then at 8:30 PM she was noted to talk loudly and argue with someone in a conversational way, replying to no one in room. *12/04/14 at 10:30 PM resident talking loudly and	F 201		

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opened lap belt 3 times.
*12/04/14 11-7 shift resident talking loudly to self at beginning of shift and gave prn Clonazepam at 2:15 am which was effective.
*12/05/14 at 11:00 PM resident heard screaming loudly all day and having conversation with people not in the room. She also unhooked lap belt several times.
*12/08/14 during the 11:00 PM to &:00 AM shift the resident talked loudly and sang until about 3:00 AM then rested remainder of shift.
*12/09/14 at 3:25 PM talking loudly to no one and unhooking lap belt.
*12/09/14 at 4:30 PM loudly talking and answering to persons not present and noted increase in vocalization.
*12/09/14 at 5:00 PM resident talking loudly, cussing.
*12/10/14 at 9:00 PM resident talking loudly to no one and answering self, opened lap belt twice.
*12/11/14 at 11:00 PM resident screaming loudly and speaking to people who were not there and redirected.
*12/12/14 at 11:00 PM Resident yelling loudly and speaking to people who were not in the room. She unhooked lap belt twice.
*12/16/14 at 8:35 PM resident's alarm sounded and found resident lying on bathroom floor. Resident explained she unhooked the alarm and rehooked it to stop alarm as she took herself to bathroom. When she fell and couldn't get back up she unhooked the alarm from the wheelchair to summon help. No injury was noted.

Review of physician telephone orders dated 12/16/14 at 10:50 PM included "if behaviors escalate notify family before sending to ER (emergency room) for eval per NP (nurse practitioner) on call"; and "May hold Seroquel

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tonight per family request."

Nursing notes dated 12/16/14 at 11:00 PM Nurse #2 wrote that the resident expressed the same story of "I took my belt off and hooked it back and walked in to bathroom and (had bowel movement) when I got done I stood up and then I fell on the floor." No injury was noted and the hall nurse reported family wanted Seroquel held tonight. The on-call nurse practitioner gave the order to hold the Seroquel and send her to the ER if behaviors escalated. The note stated Nurse #2 gave information to hall nurse and 3rd shift nurse.

On 12/17/14 at 12:30 AM nursing notes revealed Resident #6 was experiencing an increase in agitation and hallucinations. She was combative with staff and redirection was unsuccessful. The physician was notified and an order to send the resident out for a psychiatric evaluation was received. EMS (emergency medical services) was notified and the police were dispatched as well. Police arrived and resident stated there was "a bushy haired man that was out to get me." The nursing note, signed by Nurse #1, further stated "Immediate discharge notice given to resident at time of transport." This nursing note was signed by Nurse #1.

A telephone order, dated 12/17/14 and signed off at 1:15 AM by Nurse #1, included orders to send the Resident #6 to the hospital for a psych eval due to hallucinations, combativeness, and harm to self and others.

Review of the transfer sheet sent with Resident #6 to the hospital dated 12/17/14 indicated the reason for transfer was "combative

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w/staff-hallucinating speaks & answers to persons not there (present); argumentative, refusing assist, requires psych eval."

Review of the Nursing Home Notice of Transfer/Discharge dated 12/17/14 and signed by the administrator on 12/17/14 revealed Resident #6 was discharged on 12/17/14 for the marked reasons:
*The safety of individuals in this facility is endangered;
*The health of individuals in this facility would otherwise be endangered.
The notice included the handwritten reason for this notice was for "endangerment to self and/or others."
The notice indicated that in addition to notifying the resident, the legal representative (named) was also notified. The notice indicated the facility planned to "discharge" Resident #6 to (named hospital) inpatient psychiatric unit. The notice included the resident's rights to appeal the discharge. On the bottom of the notice was a handwritten note that the original was given to the resident at the time of transport and signed and dated by Nurse #1 on 12/17/14 at 2 AM.

On 12/29/14 at 3:05 PM, Nurse #2 was interviewed. Nurse #2 stated she was off 12/16/14 but Nurse #3 called her in due to Resident #6's escalating behaviors. She described Resident #6 as hallucinating, talking and answering someone who was not there. Resident #6 was more loud and verbal than usual and she would not keep her lap belt on. Nurse #2 stated staff could usually calm her down but not on this date. She would not stay in one place and was cussing and continually removed her lap belt. The nurse practitioner (NP) was called about the

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family's request to hold the Seroquel that evening. The NP gave the order to hold the Seroquel and to send her out if she did not calm down. Nurse #2 stated Resident #6 was motioning with her hands at people who were not present but was not combative. She was resistant to all interventions, eating, drinking, and watching television and the nurse was afraid to leave her unattended. Nurse #2 instructed the 3rd shift nurse (Nurse #1) to send her out if behaviors did not level out. Nurse #2 was not present when Resident #6 was sent out to the hospital.

On 12/29/14 at 3:21 PM, Nurse #3 stated during telephone interview she was Resident #6's nurse during the 3:00 PM to 11:00 PM shift on 12/16/14. She stated she was a fairly new employee and it was a very busy night so she call the nurse supervisor (Nurse #2) to come in and help her. Nurse #3 described Resident #6 as yelling and screaming more and louder than usual, but said she was not combative. Per the family request she did not give the resident her 10:00 PM Seroquel.

On 12/29/14 at 4:25 PM, the family of Resident #6 stated during telephone interview that she was informed the facility was sending the resident to the hospital but was not given a reason. Family stated she was not aware Resident #6 was being "discharged" from the facility until she found the discharge notice under the resident when the resident was transferred from the EMS gurney to the hospital gurney. The family stated then when she arrived at the hospital at approximately 2:10 AM, Resident #6 was talking incoherently but was not aggressive.

Nurse #1, who sent Resident #6 to the hospital

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F 201	Continued From page 9 on 12/17/14 was interviewed via telephone on 12/30/14 at 12:06 AM. Nurse #1 described Resident #6 as talking very loudly and hallucinating at the beginning of the shift. Her agitation increased and Nurse #1 stated the resident began to swing and kick the staff. She then stated she saw a bushy haired man who was out to get her. Nurse #1 stated that in order to give the prn Clonazepam, she would have needed to call the family for approval. Since the family had already requested no Seroquel, Nurse #1 stated she opted to use the already received order to send Resident #6 to the hospital. When asked what paperwork was sent with the resident, Nurse #1 stated the history and physical, medication administration records, the MOST form, face sheet and nursing notes. When asked about a discharge notice, Nurse #1 stated that Nurse #2 gave her a sealed envelope to give to Resident #6 if she was sent out to the hospital during the night but she did not know what it contained. Nurse #1 stated that as Resident #6 was leaving the facility with EMS, she handed the resident the envelope instructing Resident #6 to hold on to the envelope. She stated she informed the family she was being sent to the hospital for increased agitation. Several attempts to contact the nurse aide who worked with Resident #6 on 12/16/14 starting at 11:00 PM were unsuccessful. On 12/30/14 at 10:54 AM an interview was conducted with the Administrator, Director of Nursing (DON) and the Clinical Division Director. Per the Administrator the process for any resident sent to the hospital in cases that the resident was a threat to themselves or others involved staff filling out the Notice of Discharge in order to be	F 201		

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compliant with the documentation regulation related to immediate discharges. There were blank forms the Administrator had previously signed available for staff to fill out if an immediate discharge was necessary. The DON stated that with the support of the Administrator, the DON instructed Nurse #2 to fill out a discharge notice for Resident #6 and give it to Nurse #1 in case the resident was sent to the hospital during the early morning hours of 12/17/14. The DON stated she received a call just after midnight that Resident #6 was seeing things, was going to kill someone, talked about knives, was swinging so much staff were afraid she was going to hurt herself or someone else. The DON and Administrator agreed it was necessary to discharge Resident #6 for her own safety. Neither DON or Administrator were present to witness the behaviors staff described about knives and threats of harm which were not documented in the clinical record.

Interview with the Clinical Division Director revealed on 12/30/14 at 12:45 PM the NP who gave the verbal order to send Resident #6 out to the hospital if behaviors escalated was the on-call NP who did not come to this facility and was unfamiliar with the resident.

A phone interview with Resident #6's physician was conducted on 12/30/14 at 12:53 PM. The physician stated he had seen Resident #6 a couple of weeks prior to the 12/17/14 discharge. He stated she had dementia and was stable the last time he saw her. He further described that 'her switch could be tripped quickly' indicating she could be calm and exhibit hallucinations and behaviors quickly. He stated he was informed by a nurse after the resident was sent to the hospital

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F 201	Continued From page 11 that she had been hitting, resisting care, communicating threats such as going to kill someone, and that her behaviors were out of control. The physician stated that if he received the call earlier in the shift related to the family's request to hold the Seroquel, he would not have held the Seroquel as he felt this medication may have helped her behaviors improve. The physician further stated he was not involved in the decision to not accept the resident back from the ER.	F 201		
F 203 SS=D	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 as specified in paragraph (a)(5)(ii) and (a)(8) 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	F 203		1/21/15

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(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	Continued From page 12 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 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 record review, staff interviews and family interviews, the facility failed to notify the resident and family prior to issuing an immediate discharge notice to 1 of 3 sampled residents reviewed for discharges (Resident #6). The findings included: Resident #6 was admitted to the facility on 07/02/13. Her diagnoses included muscle weakness, bipolar disorder, mood disorder and depression. The medical record revealed she	F 203	Written Notification of Discharge provided to Responsible Party of Resident #6. All residents identified as having the potential to be affected. Audit completed by Administrator to identify written notification is provided to other residents/responsible parties who have been discharged in the last 30 days. Review of Notice Requirements before	

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F 203	Continued From page 13 had been under the care of psychiatric services in the facility since 08/07/13 due to periods of yelling out, confusion and wandering. Review of the medical record revealed Resident #6 was seen by the consultant psychiatric nurse practitioner (psych NP) on 09/10/14, 10/01/14, 10/08/14, 10/23/14, and 11/13/14. During these visits, medications had been changed to address behaviors and insomnia. Nursing notes for November 2014 revealed Resident #6 exhibited behaviors including talking loudly, cursing, yelling, hallucinating and/or removing her self release lap belt on: 11/14/14 around 7:30 PM; 11/14/14 at 4:00 AM; 11/15/14 at 1 :00 PM; 11/16/14 at 1:00 PM; and on 11/19/14 at 6:30 PM. On 11/21/14 at 9:20 AM, nursing notes revealed the family expressed concern about Resident #6 being lethargic. The nurse explained the resident was being treated for a urinary tract infection which could cause lethargy but the family insisted she be sent to the hospital. Nursing notes revealed she returned from the hospital on 11/21/14 at 1:45 PM. The nursing note stated the nurse spoke to the emergency room physician who stated the resident's altered mental status was related to her urinary tract and infection and the antibiotics would resolve that issue. The nurse practitioner was called per family request and orders were received for the reduction of medications. A telephone order by the nurse practitioner dated 11/24/14 decreased the antipsychotic medication per family request. The nursing note dated 11/24/14 at 11 AM noted the medication changes	F 203	Transfer/Discharge completed by Administrator with Social Service Director, Social Service Assistant, and Director of Nursing to ensure compliance. Monitoring tool implemented to ensure notice requirements before transfer/discharge are met. Administrator to complete monitoring tool related to notice requirements before transfer/discharge for each discharging/transferring resident 3 times weekly for 2 weeks; then once weekly for 2 weeks; then once monthly for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly for 3 months.	

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and noted the resident had been yelling, using derogatory language and saying profane things about family and others.

Nursing notes revealed continued hallucinations on 11/24/14 at 3:00 PM; 11/28/14 at 2:00 PM; 11/29/14 at approximately 3:30 AM; and 11/30/14 at 2:30 PM.

Resident #6's most recent Minimum Data Set, a quarterly dated 11/26/14, coded her with a score of 12 out of 15 on the brief interview for mental status which indicated she was cognitively intact. She required extensive assistance for most activities of daily living skills, was coded for no delirium and no behaviors, received anti-psychotropic medications and had falls.

Nursing notes documented ongoing hallucinations and/or removing self release lap belt on:
12/01/14 during the 11:00 PM to 7:00 AM shift; 12/02/14 at 8:00 PM; 12/02/14 at 11:00 PM; 12/03/14 at 8:30 PM; 12/04/14 at 10:30 PM; 12/04/14 during the 11:00 PM to 7:00 AM shift; 12/05/14 at 11:00 PM; 12/08/14 during the 11:00 PM to 7:00 AM shift; 12/09/14 at 3:25 PM; 12/09/14 at 4:30 PM; 12/09/14 at 5:00 PM; 12/10/14 at 9:00 PM; 12/11/14 at 11:00 PM; and on 12/12/14 at 11:00 PM.

Review of physician telephone orders dated 12/16/14 at 10:50 PM included "if behaviors escalate notify family before sending to ER (emergency room) for eval per NP (nurse practitioner) on call"; and "May hold Seroquel tonight per family request."

Nursing notes dated 12/16/14 at 11:00 PM,

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written by Nurse #2, wrote the hall nurse reported family wanted Seroquel held tonight (following a fall). The on-call NP gave the order to hold the Seroquel and send her to the ER if behaviors escalated. The note stated Nurse #2 gave information to hall nurse and 3rd shift nurse.

On 12/17/14 at 12:30 AM nursing notes revealed Resident #6 was experiencing an increase in agitation and hallucinations. She was combative with staff and redirection was unsuccessful. The physician was notified and an order to send the resident out for a psychiatric evaluation was received. EMS (emergency medical services) was notified and the police were dispatched as well. Police arrived and resident stated there was "a bushy haired man that was out to get me." The note further stated "Immediate discharge notice given to resident at time of transport." This note was signed by Nurse #1.

A telephone order dated 12/17/14 and signed off at 1:15 AM by Nurse #1 was to send the resident to the hospital for a psych eval due to hallucinations, combativeness, and harm to self and others. This was ordered by the on-call NP.

Review of the transfer sheet sent with Resident #6 to the hospital dated 12/17/14 indicated the reason for transfer was "combative w/staff-hallucinating speaks & answers to persons not there (present); argumentative, refusing assist, requires psych eval."

Review of the Nursing Home Notice of Transfer/Discharge dated 12/17/14 and signed by the administrator on 12/17/14 revealed Resident #6 was discharged on 12/17/14 for the marked reasons:

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*The safety of individuals in this facility is endangered;
*The health of individuals in this facility would otherwise be endangered.
The notice included the handwritten reason for this notice was for "endangerment to self and/or others."
The notice indicated that in addition to notifying the resident, the legal representative (named) was also notified. The notice indicated the facility planned to "discharge" Resident #6 to (named hospital) inpatient psychiatric unit. The notice included the resident's rights to appeal the discharge. On the bottom of the notice was a handwritten note that the original was given to the resident at the time of transport and signed and dated by Nurse #1 on 12/17/14 at 2 AM.

On 12/29/14 at 3:05 PM, Nurse #2 was interviewed. Nurse #2 stated she was off 12/16/14 but Nurse #3 called her in due to Resident #6's escalating behaviors. She described Resident #6 as hallucinating, talking and answering someone who was not there. Resident #6 was more loud and verbal than usual and she would not keep her lap belt on. Nurse #2 stated staff could usually calm her down but not on this date. She would not stay in one place and was cussing and continually removed her lap belt. The nurse practitioner was called about the family's request to hold Seroquel that evening and she gave the order to send her out if she did not calm down. Nurse #2 stated she was motioning with her hands at people not present but was not combative. She was resistant to all interventions, eating, drinking, and watching television and the nurse was afraid to leave her unattended. Nurse #2 instructed the 3rd shift nurse (Nurse #1) to send her out if behaviors did

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F 203	Continued From page 17 not level out. Nurse #2 was not present when Resident #6 was sent out to the hospital. On 12/29/14 at 3:21 PM, Nurse #3 stated during telephone interview she was Resident #6's nurse during the 3:00 PM to 11:00 PM shift on 12/16/14. She stated she was a fairly new employee and it was a very busy night so she called the nurse supervisor (Nurse #2) to come in and help her. Nurse #3 described Resident #6 as yelling and screaming more and louder than usual, but said she was not combative. Per the family request she did not give the resident her 10:00 PM Seroquel. Nurse #3 stated she could not recall details but thought Nurse #2 handled all the details and called the family. On 12/29/14 at 4:25 PM, the family of Resident #6 stated during telephone interview that she was informed the facility was sending the resident to the hospital but was not given a reason. Family stated she was not aware Resident #6 was being "discharged" from the facility until she found the discharge notice under the resident when the resident was transferred from the EMS stretcher to the hospital stretcher. Nurse #1, who sent Resident #6 to the hospital on 12/17/14 was interviewed via telephone on 12/30/14 at 12:06 AM. Nurse #1 described Resident #6 as talking very loudly and hallucinating at the beginning of the shift. Her agitation increased and Nurse #1 stated she began to swing and kick the staff. She then stated Resident #6 saw a bushy haired man who was out to get her. Nurse #1 stated she opted to use the order received earlier on second shift to send Resident #6 to the hospital. When asked what paperwork was sent with the resident, Nurse	F 203		

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#1 stated the history and physical, medication administration records, the MOST form, face sheet and nursing notes. When asked about a discharge notice, Nurse #1 stated that Nurse #2 gave her a sealed envelope to give to Resident #6 if she was sent to the hospital. Nurse #1 stated she handed Resident #6 the envelope with instructions for Resident #6 to hold on to the envelope as she was leaving the facility with EMS. Nurse #1 stated she did not know what was in the envelope. She stated she informed the family she was being sent to the hospital for increased agitation. She stated she did not know Resident #6 was being discharged from the facility.

On 12/30/14 at 10:54 AM an interview was conducted with the Administrator, Director of Nursing (DON) and the Clinical Division Director. Per the Administrator the process for any resident sent to the hospital in cases that the resident was a threat to themselves or others involved staff filling out the Notice of Discharge in order to be compliant with the documentation regulation. There were blank forms the Administrator had previously signed for staff to fill out if the discharge was necessary for safety reasons. The DON stated that with the support of the Administrator, the DON instructed Nurse #2 to fill out a discharge notice for Resident #6 and give it to Nurse #1 in case the resident was sent to the hospital early on 12/17/14. The DON stated she received a call just after midnight that Resident #6 was seeing things, was going to kill someone, talked about knives, was swinging so much staff were afraid she was going to hurt herself or someone else. The DON and Administrator agreed to discharge Resident #6 for her safety. Neither DON or Administrator were present to

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F 203	Continued From page 19 witness the behaviors staff described but did not document in the clinical record. The Administrator stated she expected Nurse #1 to explain the need for immediate discharge to the family and the resident. A phone interview with Resident #6's physician was conducted on 12/30/14 at 12:53 PM. The physician stated he had seen Resident #6 a couple of weeks prior to the 12/17/14 discharge. He stated she had dementia and was stable the last time he saw her. He further described that 'her switch could be tripped quickly' indicating she could be calm and exhibit hallucinations and behaviors quickly. He stated he was informed by second shift nurse after resident #6 was transferred to the hospital that she had been hitting, resisting care, communicating threats such as going to kill someone, and that her behaviors were described as out of control. The physician stated that if he had received the call earlier in the shift, he would probably have not held the Seroquel per family request as that may have helped her behaviors improve. The physician further stated he was not involved in the decision to not accept the resident back from the ER.	F 203		
F 206 SS=D	483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility	F 206		1/21/15

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F 206	Continued From page 20 services. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, family interviews, physician interview, and interviews with hospital personnel, the facility failed to readmit a resident to the first available bed for 1 of 3 sampled residents who were discharged (Resident #6). The findings included: Resident #6 was admitted to the facility on 07/02/13. Her diagnoses included muscle weakness, bipolar disorder, mood disorder and depression. The medical record revealed she had been under the care of psychiatric services in the facility since 08/07/13 due to periods of yelling out, confusion and wandering. Review of the medical record revealed Resident #6 was seen by the consultant psychiatric nurse practitioner (psych NP) on 09/10/14, 10/01/14, 10/08/14, 10/23/14, and 11/13/14. during these visits, medications had been changed to address behaviors and insomnia. Nursing notes for November 2014 revealed Resident #6 exhibited behaviors including talking loudly, cursing, yelling, hallucinating and/or removing her self release lap belt on 11/14/14 around 7:30 PM; 11/14/14 at 4:00 AM; 11/15/14 at 1 :00 PM; 11/16/14 at 1:00 PM; and 11/19/14 at 6:30 PM. A telephone order by the nurse practitioner (NP) dated 11/24/14 decreased the antipsychotic	F 206	Resident #6 discharged home with RP on 12/17/14. Complete assessment for re-admission to first available bed for Resident #6. Multiple attempts have been made to contact RP for Resident #6 to complete assessment for re-admission to first available bed have been unsuccessful. Director of Nursing contacted RP of Resident #6 on 1/16/15 with no return call. Social Worker Assistant contacted RP of Resident #6 on 1/14/15 and 1/21/15 with no return call. All residents identified as having the potential to be affected. Audit completed by Social Service Director to identify re-admission potential for residents discharged in the last 30 days. Review of Re-Admission to First Available Bed requirements completed by Administrator with Social Service Director, Social Service Assistant, and Director of Nursing to ensure compliance. Monitoring tool implemented to ensure readmission to first available bed beyond bed-hold for discharged residents. Monitoring tool to be completed by Administrator for all discharged residents 3 times weekly for 2 weeks; then once	

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F 206	Continued From page 21 medication per family request. The nursing note dated 11/24/14 at 11:00 AM noted the medication changes and noted the resident had been yelling, using derogatory language and saying profane things about family and others. Nursing notes for Resident #6 revealed continued behaviors including talking loudly, cursing, yelling, hallucinating and/or removing her self release lap belt on 11/24/14 at 3:00 PM; 11/28/14 at 2:00 PM; 11/29/14 at approximately 3:30 AM; and 11/30/14 at 2:30 PM. Resident #6's most recent Minimum Data Set, a quarterly dated 11/26/14, coded her with a score of 12 out of 15 on the brief interview for mental status which indicated she was cognitively intact. She required extensive assistance for most activities of daily living skills, was coded for no delirium and no behaviors, receiving anti-psychotropic medications and having falls. Nursing notes documented ongoing hallucinations and/or removing self release lap belt on 12/01/14 during the 11:00 PM to 7:00 AM shift; 12/02/14 at 8:00 PM; 12/02/14 at 11:00 PM; 12/03/14 at 8:30 PM; 12/04/14 at 10:30 PM; 12/04/14 11-7; 12/05/14 at 11:00 PM; 12/08/14 during the 11:00 PM to 7:00 AM shift; 12/09/14 at 3:25 PM; 12/09/14 at 4:30 PM; 12/09/14 at 5:00 PM; 12/10/14 at 9:00 PM;12/11/14 at 11:00 PM; and 12/12/14 at 11:00 PM. Review of physician telephone orders revealed that on 12/16/14 at 10:50 PM "if behaviors escalate notify family before sending to ER (emergency room) for eval per NP (nurse practitioner) on call"; and "May hold Seroquel (an antipsychotic medication) tonight per family	F 206	weekly for 2 weeks; then once monthly for 3 months. Results of Monitoring Tool will be incorporated in monthly Quality Assurance and Performance Improvement program to evaluate for compliance and effectiveness monthly for 3 months.	

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request."

Nursing notes dated 12/16/14 at 11:00 PM, written by Nurse #2, wrote the hall nurse reported family wanted Seroquel held tonight (following a fall). The on-call NP gave the order to hold the Seroquel and send her to the ER if behaviors escalated. The note stated Nurse #2 gave information to hall nurse and 3rd shift nurse.

On 12/17/14 at 12:30 AM nursing notes revealed Resident #6 was experiencing an increase in agitation and hallucinations. She was combative with staff and redirection was unsuccessful. The physician was notified and an order to send the resident out for a psychiatric evaluation was received. EMS (emergency medical services) was notified and the police were dispatched as well. Police arrived and resident stated there was "a bushy haired man that was out to get me." The note further stated "Immediate discharge notice given to resident at time of transport." This note was signed by Nurse #1.

A telephone order dated 12/17/14 and signed off at 1:15 AM by Nurse #1 was to send the resident to the hospital for a psych eval due to "hallucinations, combativeness, and harm to self and others."

Review of the transfer sheet sent with Resident #6 to the hospital dated 12/17/14 indicated the reason for transfer was "combative w/staff-hallucinating speaks & answers to persons not there (present); argumentative, refusing assist, requires psych eval."

Review of the Nursing Home Notice of Transfer/Discharge dated 12/17/14 and signed by

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the Administrator on 12/17/14 revealed Resident #6 was discharged on 12/17/14 for "endangerment to self and/or others." The notice indicated the facility planned to "discharge" Resident #6 to (named hospital) inpatient psychiatric unit.

Review of the hospital ER's records for Resident #6's hospital stay on 12/17/14 revealed the chief complaint at 2:05 AM was increased agitation after withholding Seroquel per family wishes. The clinical impression at this time was a urinary tract infection. The resident was noted to have no thoughts of harming herself. The hospital report further revealed:
*12/17/14 at 2:29 AM resident was oriented to person and place, she was awake and alert and speech was slurred.
*12/17/14 8:12 AM behavior was cooperative, pleasant, she was awake, alert and obeyed commands.
*12/17/14 at 8:28 AM the facility was refusing to take resident back to facility saying she was discharged.
*12/17/14 at 1:45 PM the facility's admission coordinator called requesting a copy of the psych eval. Doctor will order one.
*12/17/14 at 3:16 PM the psych assessment staff, a registered nurse, evaluated Resident #6. The resident reported she was not getting her medication. She was described as alert and oriented to time, place and person. Her concentration was described a stable to attend to task. Her memory was described as being within normal limits. Her behavior was described as cooperative with no evident delusions. The clinical summary stated "upon interview pt (patient) is mood and behaviorally stable; no acute psych symptoms present."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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*12/17/14 at 7:27 PM the hospital social worker called the facility Administrator after confirmation that the psych eval for Resident #6 was faxed and received by facility. The Administrator reported that the evaluation was not acceptable as a physician did not do the evaluation.
*12/17/14 at 7:33 PM the resident's facility physician asked the ER to admit the resident but there was no medical reason. The family decided to take Resident #6 home.

On 12/29/14 at 1:03 PM hospital social worker (HSW) #2 was interviewed via phone. HSW #2 reported that Resident #6 was sleepy in the morning of 12/17/14 and as the day wore on, she became more alert and awake. She then started talking loudly into the evening. HSW #2 stated Resident #6 exhibited no signs of aggressive behaviors and was just talking loudly and hallucinating. The doctor in the ER evaluated her and did not see any evidence to warrant admission. She reported that the nursing home was not willing to take Resident #6 back without a psych eval completed by a psychiatrist. She further stated HSW #1 was also involved in the discussions involving trying to send Resident #6 back to the facility.

A telephone interview was conducted with HSW #1 on 12/20/14 at 7:39 PM. HSW #1 stated when she arrived at work the hospital was ready to send her back to the facility but the facility was unwilling to accept her back until there was a psych eval. Once that was completed and sent to the facility, the facility still refused to accept the resident back because the psych eval was not completed by a psychiatrist just the hospital psych assessor. She stated that during her shift (12:00 PM to 9:00 PM) Resident #6 was not

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	345169	A. BUILDING ______ B. WING ______	C 12/30/2014

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combative but did hallucinate. The physician at the hospital did not feel there was just cause to admit Resident #6. The family had expressed the desire to have Resident #6 return to the facility but after several hours, took the resident home.

The facility's admission coordinator was interviewed on 12/30/14 at 10:05 AM. She stated she was contacted on 12/17/14 by the hospital stating Resident #6 was ready to return. As admissions coordinator she stated she usually did not get involved in residents returning from the hospital. The admissions coordinator then talked with the facility Administrator who expressed wanted a psychiatric evaluation for Resident #6 before she could return to the facility. The admissions coordinator referred the HSW to the Administrator and the admissions coordinator was then no longer involved with Resident #6's readmission.

A telephone interview with Resident #6's family on 12/30/14 at 10:19 AM revealed the family wanted to have Resident #6 return to the facility on 12/17/14. She admitted she was looking for alternative placement for Resident #6 prior to the transfer to the hospital on 12/17/14 but wanted Resident #6 to return to the facility until a transfer to another facility could be arranged.

On 12/30/14 at 10:54 AM an interview was conducted with the Administrator, Director of Nursing (DON) and the Clinical Division Director. The DON stated she received a call just after midnight on 12/17/14 that Resident #6 was seeing things, was going to kill someone, talked about knives, was swinging so much staff were afraid she was going to hurt herself or someone else. The DON and Administrator agreed to

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F 206	Continued From page 26 discharge Resident #6 for her own safety. The Administrator and DON stated that the reason they refused to readmit Resident #6 was because the resident was not seen by a "psychiatrist" at the hospital. If she had been seen by a psychiatrist, was not admitted to the hospital and deemed safe to return to the facility, then they would have taken her back. A phone interview with Resident #6's physician was conducted on 12/30/14 at 12:53 PM. He stated he was informed by second shift nurse after the resident was sent to the hospital that she had been hitting, resisting care, communicating threats such as going to kill someone, and that her behaviors were described as out of control. The physician stated that if he had received the call earlier in the shift, he would probably have not held the Seroquel per family request as that may have helped her. The physician further stated he was not involved in the decision to not accept the resident back from the ER.	F 206		