STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 02/01/2019

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 000	INITIAL COMMENTS	F 000		

A complaint investigation survey was conducted from 1/22/19 -1/25/19. An interview was conducted on 1/26/19. The survey team returned to the facility on 1/28/19 through 2/1/19.

The following Immediate Jeopardy citation was identified at:

CFR 483.21 at tag F660 at a scope and severity (J).

Immediate Jeopardy began on 12/13/18 and was removed on 2/1/19.

Tag F689 constituted Substandard Quality of Care.

Past-noncompliance was identified at:

CFR 483.25 at tag F689 at a scope and severity (J)

The deficient practice for F689 began on 1/15/19 and was corrected on 1/19/19.

A Partial extended survey was conducted.

The credible allegation of removal was amended on 3/1/19.

An amended Statement of Deficiencies was provided to the facility on 4/4/19 because of the results of the facility's Informal Dispute Resolution (IDR). Tags F-600 and F-624 were deleted and the information in tag 0000 was changed to reflect the results of the IDR. Event #CJIL11. F624 is added back to the 2567 after CMS review

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

Electronically Signed | 02/21/2019

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F 000	Continued From page 1 of the IDR materials	F 000		
F 624 SS=J	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with Adult Protective Services Worker, Medical Doctor, Ombudsman, Transportation Company Staff, Home Health Agency Worker, Emergency Medical Technician, former and current facility staff members and former resident the facility failed to provide 1 of 4 sampled residents (Resident #12) who were reviewed for discharge with a safe discharge planning process that included discharge goals, needs and caregiver support for Resident #12. The facility failed to ensure 1 of 4 sample residents (Resident #12) discharge to have a safe place to go to after leaving the facility. The facility failed to assess Resident #12's medical condition and complete a home assessment to identify possible barriers for a safe discharge home. Immediate jeopardy began on 12/13/2018 when the facility failed to provide and document sufficient preparation and orientation to Resident #12 to ensure safe and orderly discharge from the facility. The facility failed to train and orient the resident and or family representative on	F 624	F 624 J Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #12 was admitted on 5/23/2018 for short term rehabilitation services. Resident #12 received skilled nursing and rehabilitation services from 5/23/2018 up to 7/11/2018. Resident #12 was discharged from Medicare covered skilled services on 7/11/2018 after she met her therapy goals. Resident #12 remained in the facility after 7/11/2018 for custodial care without a payer source. On 10/10/2018, the facility Business Office Manager and Assistant Business Office Manager discussed with resident #12 regarding her failure to make payment arrangement for her stay in the facility. Resident #12 voiced the understanding of her financial obligation.	2/20/19

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F 624	Continued From page 2 administering medications, checking blood sugar and self-administration of insulin or any other medical treatment. The facility failed to have a discussion with the resident the safety of the home environment in relation to the resident's physical condition and ability to maneuver at home, the resident's basic needs of food, water, electricity and heat and medical care needs. Immediate Jeopardy was removed on 02/01/19 at 3:45pm based on the allegation of compliance that was provided. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to training of facility staff regarding the discharge planning process. The Findings included: Resident #12 was admitted to the facility on 5/23/2018 with diagnoses that included heart failure, diabetes, chronic obstructive pulmonary disease, asthma, depression, neuropathy and muscle weakness. Review of the hospital discharge summary dated 5/23/18 revealed Resident #12 was found at home in her bathtub by Emergency Medical Services (EMS). The patient reported she had called out for several days for help and her neighbors had called EMS because they had not heard from the patient for several days. EMS noted that the patient's home was "knee-deep" with trash that was full of rats and roaches. The patient was found to have a blood sugar of 690 milligrams per deciliter (mg/dl).	F 624	On 11/15/2018; Business Office Manager provided resident #12 with the 30 □ days discharge notice since resident #12 failed, after reasonable and appropriate notice to pay for her stay at the facility. Resident #12 discharge date was set for 12/13/2018. On 12/13/2018, Resident #12 was discharged from the facility to her private home after the 30 days discharge notice expired. Facility arranged transportation to transport resident #12 to her private home via licensed non-emergency transportation company. Although resident #12 failed to pay for her stay at the facility, after reasonable and appropriate notice was given, the state survey agency alleged that; the facility failed to provide and document sufficient preparation and orientation to resident #12 to ensure safe and orderly discharge from the facility. The facility failed to train and orient the resident and or family representative on administering medications, checking blood sugar and self-administration of insulin or any other medical treatment. The facility failed to have a discussion with the resident and or family representative to address the safety of the home environment in relation to the resident□s physical condition and ability to maneuver at home, the resident□s basic needs of food, water, electricity and heat and medical care needs. The facility failed to discuss with the resident and or family representative the level and type of	

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F 624	Continued From page 3 Record review of a social service progress note dated 5/29/18 for Resident #12 stated Adult Protective Services (APS) was working with the resident and identified the resident's home would need to be cleaned before she could return home. The resident planned to return home after she completed therapy, stabilized her medical condition and had her home cleaned. Record review of a care plan for Resident #12 dated 6/15/18 revealed the resident desired to return home with a goal identified that she would return home with supportive services. Interventions included the facility would evaluate the resident's home for possible barriers, schedule a family meeting to discuss post change needs, assist the resident with obtaining community resources for discharge, notify the residents physician to discuss concerns and obtain orders for discharge supplies. Record review of a social service progress note dated 7/6/18 for Resident #12 stated the Social Worker (SW) had informed the resident her last day of Medicare coverage was 7/11/18. The SW explained the non-coverage letter, advanced beneficiary notice letter and appeal process and rights to the resident. Resident #12 expressed to the SW that she was not ready to return home and may have to get her lawyer involved if the facility was going to throw her out. The SW explained to the resident that the facility was not throwing her out but providing this information per protocol and Medicare guidelines. After continued discussion with the resident she decided she would appeal the decision and a follow-up meeting was planned after notification of the appeal decision.	F 624	support the resident needed from her family, significant others, the community, home health agencies, and any other government agencies and how the facility will assist the resident in getting the support and assistance she needed. The facility also failed to validate the post-discharge care is appropriate to meet resident #12 needs, and failed to validate orientation was provided in a form and manner that the resident #12 understood. Resident #12 was transferred to the hospital for generalized weakness on 12/13/2018 from her private home. Hospital records indicated resident #12 was unable to take care of herself at her home. Resident #12 is no longer in the facility, no further actions warranted at this time. On 1/30/19; Chief Clinical Officer from the Management and consulting company contracted by the facility, conducted the root cause analysis for this alleged noncompliance. The analysis concluded the alleged noncompliance resulted from the facility□s failure to provide and document sufficient preparation and orientation to resident #12 to ensure safe and orderly discharge from the facility. The facility also failed to validate the post-discharge care is appropriate to meet resident #12 needs, and failed to validate orientation was provided in a form and manner that the resident #12 understood.	

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F 624	Continued From page 4 Record review of a quarterly Minimum Data Set (MDS) dated 11/15/18 for Resident #12 revealed her cognition was intact and an active discharge plan was in place for the resident to return to the community. She required extensive two-person assistance with bed mobility, transfers, personal hygiene and extensive one-person assistance with dressing, toilet use and bathing. She was incontinent of bowel and bladder. Review of MDS dated 11/15/2018 indicated that Resident #12's weight was 389 pounds and her height was 71 inches tall. Record review of a transfer / discharge notice for Resident #12 dated 11/15/18 from the facility Administrator stated the date of discharge was 12/15/18. The reason for the transfer / discharge was Resident #12 after having received reasonable and appropriate notice failed to pay (or have paid under Medicare / Medicaid) for her stay at the facility. This information was given to Resident #12 and the Ombudsman on 11/15/2018. Record review of a social service progress note dated 11/15/18 for Resident #12 stated discharge plans were discussed with the resident and she would like to discharge back to her home. The resident requested home health services upon discharge. The writer inquired about transfers as well as assistance needed with toileting and the resident stated she would like continued supervision with her activities of daily living (ADLs) until discharge to ensure her balance and stability for transfers using the sliding board. The resident was currently working with therapy and the writer informed the therapy team of resident's request for assistance with transfers. The discharge paperwork was reviewed with the	F 624	Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. Audits of 100% of residents discharge documentation in the last 90 days were completed by the Director of Nursing, assistant Director of nursing, Staff Development coordinator and/or unit manager on 1/30/19 to identify if any other resident was discharged without sufficient preparation and orientation to ensure safe and orderly discharge from the facility. No other resident was identified to be affected by this alleged noncompliance. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 1/30/2019 the Director of Nursing, Director of Rehabilitation Center, Staff Development coordinator and/or Director of Social services will be responsible to initiate and train/provide the needed education to either resident and/or resident representative, or will train the designated licensed nurse who will then train the resident and/or resident representative. This education/training will take place at least three days before resident is discharged from the facility. Staff members who will be responsible to educate residents or residents representative include; Director of Nursing, Director of Rehabilitation Center,	

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F 624	Continued From page 5 resident including her right to appeal. The resident stated appealing was a waste of time and she would like to go home. The writer would prepare the resident to return home and set up assistance closer to her discharge date. Record review of a social services progress note dated 12/12/18 for Resident #12 stated discharge plans were reviewed again with the resident to ensure she was prepared for her transfer home on 12/13/18. The resident will discharge to her home per her choice. She was provided with options for independent living and assisted living facilities on numerous occasions, but the resident declined. The resident will transport home and receive home care services with the home health company of her choice. Her motorized wheelchair was in place as well as a bedside commode that was ordered by the facility. The resident expressed that her family and friends will assist her with the transition and check in on her periodically. There were no concerns brought to the attention of this writer by the resident. Record review of the discharge summary for Resident #12 dated 12/12/18 at 1:19 pm revealed her physical home address, physicians name and number, discharge notes to the Ombudsman and home health services phone number and allergies with any adverse reactions. Attached to the discharge summary was a list of the residents' medications and her care plan. Record review of a departmental note dated 12/13/18 for Resident #12 revealed the resident was alert and oriented, able to make needs know. No acute distress noted. The resident required assistance with ADLs, 2 person assist using mechanical lift with transfers. The resident took	F 624	Staff Development coordinator, Director of social services #1 or #2. And/or discharging nurse. The education will be intended to train and orient the resident and or family representative on the resident□s medical care needs including but not limited to administering medications, checking blood sugar, self-administration of insulin or any other medical treatment. The facility will have a discussion with the resident and or family representative to address the resident□s safety including but not limited to home environment in relation to the resident□s physical condition and ability to maneuver at home, the resident□s basic needs of food, water, electricity and heat and medical care needs or any other issues that are relevant to the safety of the resident. The facility will discuss with the resident and or family representative the level and type of support the resident needed from her family, significant others, the community, home health agencies, and any other government agencies and how the facility will assist the resident in getting the support and assistance she needed. The facility will discuss with the resident and or family representative any other issues the facility can help the resident to have a safe and orderly discharge as identified in the resident□s discharge planning on the comprehensive care plan. Effective 1/30/19 the facility will conduct a weekly Case Management meeting chaired by the facility Administrator, MDS nurse, Director of Rehabilitation and/or	

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F 624	Continued From page 6	F 624		

her meds without any problems, she was incontinent of bowel and bladder, breathing was even and unlabored. Blood sugar was checked, and insulin coverage provided.

Record review of a social service progress note dated 12/13/18 revealed APS was informed of the resident's choice to return home verses transfer to an independent or assisted living facility. Home health services were set up per request of the resident. The writer spoke with APS to alert case worker that the resident was being discharged home with home health services.

Record review revealed Resident #12 was transported home on 12/13/18 2:30pm by a transportation company that was paid for by the facility.

An EMS report dated 12/13/18 7pm revealed EMS was dispatched to Resident #12's home for a sick call. A 63-year-old female complained of sitting in her motorized wheelchair. She reported she had been discharged home from the nursing home this afternoon after staying there for 7 months. She reported she arrived home about 2:00 pm today and was unable to transfer from her wheelchair to the toilet. The patient reported she was not able to complete her rehab while at the facility.

Review of the hospital records dated 12/13/18 for Resident #12 identified her chief complaint was generalized weakness and unable to take care of herself. The patient had a history of atrial fibrillation, asthma, chronic kidney disease, chronic heart failure, depression, diabetes and hypertension. She had been at a skilled nursing facility for the past 7 months and was unable to

Director of Nursing. Residents with pending discharges will be discussed in this meeting at least a week in advance to allow the Director of Social Services #1 and/or #2 at least seven days to make necessary arrangements to ensure sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand. During this meeting the person who is going to orient the resident will be assigned.

Effective 1/30/19 and moving forward the facility will conduct home visits as deemed appropriate and necessary by the facility licensed therapist and/or director of nursing to ensure resident□s home is safe for the resident. Each resident will receive appropriate preparation, orientation and education individualized based on the findings from home visit before the discharge to ensure resident has a safe and orderly discharge. The education and home visits will be conducted prior to resident□s discharge. The home visit will be documented on the home visit checklist form and maintained in resident□s medical records. The facility will validate orientation was provided in a form and manner that the resident will understand. In the instance where the resident is unable to understand, resident□s representative will be educated and/or Adult protective services will be notified effective 1/30/2019

Effective 1/30/19 the facility will conduct a discharge meeting and work with the

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F 624	Continued From page 7 take care of her bill, so she was discharged home this morning. She was unable to walk and used a motorized wheelchair. She had to go to the bathroom but was not able to get to the bedside commode, so she called EMS. EMS found the resident covered in urine and stool. The patient admitted to dysuria for the past couple days and a work up in the emergency room revealed a urinary tract infection and received 1 dose or Rocephin (an antibiotic). The patient was discharged from the hospital to a skilled nursing facility on 12/19/18. An interview with the former Social Worker (SW) on 1/25/2018 at 11:00am revealed she discharged Resident #12 on 12/13/2018. The SW indicated the resident wanted to go home and indicated she had neighbors to help her. The SW stated there were no family members present with the resident when she was discharged on 12/13/18. She added the facility arranged for the transportation company that took the resident home. She explained she had contacted APS and informed them that Resident #12 was being transferred home. The SW added that Resident #12 did not want to go to another facility and she only wanted to go home. SW also indicated she never made a home visit to Resident #12's home. SW indicated she had no knowledge of another cleaning up Resident #12's home. An interview with the physical therapy staff member on 1/25/19 at 11:30 am revealed they had worked with Resident #12 prior to being discharged. The staff member stated the resident had not completed her goals and would not have been able to care for herself at home alone. She added Resident #12 would have had a hard time trying to transfer herself from her wheelchair to	F 624	resident and/or resident representative, if applicable, to develop interventions to meet each resident□s discharge goals and to ensure a sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand. Any identified barriers will be addressed before the resident is discharged from the facility and hence reduce factors leading to preventable readmissions to the hospital. This review will take place daily Monday through Friday effective 1/30/19. Effective 1/30/2019 the director of social services will be ultimately responsible to coordinate all discharge meetings in the facility. The facility will not discharge any resident from the facility until the facility validates that all services are arranged and the resident is safe to be discharged effective 1/30/2019 Effective 1/30/19 and moving forward the facility director of social services #1 or #2 and/or discharging licensed nurse will provide and document sufficient preparation and orientation to residents and/or resident representative if applicable to ensure safe and orderly transfer or discharge. This orientation will be provided in a form and manner that the resident can understand. This education will be documented in resident□s medical records. Regional Clinical Consultant from the contracted Management and consulting company conducted re-education for current facility interdisciplinary team	

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F 624	Continued From page 8 the toilet without assistance. An interview with Nursing Aide #1 (NA) on 1/25/19 at 11:45 am who worked with Resident #12 during her stay at the facility revealed the resident needed assistance with all her ADLs, however she could feed herself. NA # 1 added the resident wanted to go home. An interview with the Director of Nursing (DON) on 1/25/2019 at 11:00 am revealed she had no knowledge of Resident #12's discharge. DON indicated that the former Social Worker handled that discharged. An interview with the Administrator on 1/25/2019 at 1:00 pm revealed the SW completed the discharge for Resident #12 and she was unaware that the facility paid for this resident to be transported home. She stated she did not know if someone had made a home visit prior to Resident #12's discharge. Pre phone interview on 1/25/19 at 1:30 pm with a staff member of the skilled nursing facility that Resident #12 was currently residing at revealed the resident was admitted on 12/19/18 and required extensive to total assistance with her ADL's except she could feed herself with staff set-up. During an interview with Resident #12 on 1/26/2019 at 2:00 pm revealed she was at the former facility for 8 months. She stated she told the facility she wanted to go home however she knew that she could not take care of herself. Resident #12 added the facility kicked her out because she had not paid them. She stated she had completed the Medicaid applications to get	F 624	involved on discharge planning to include the Administrator, Director of Nursing, Director of Social services #1 and #2, Activity Director, Director of Rehabilitation services, MDS nurse and staff development coordinator on 1/30/19. This education emphasized on the importance of providing sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident□s representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). This education will be completed by 1/30/19, any department head not educated by 1/30/19 will not be allowed to work until educated. Effective 1/30/19 this education will be added on new hires education and provided annually for all new facility department heads. The Facility Director of Nursing (DON), Assistant Director of Nursing and/or staff development coordinator will complete 100% education on the importance of providing sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident□s representative if applicable	

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help but never but she never heard back. Resident #12 stated she did want to go home but with services in place. She added the facility knew she didn't have any family or support to help her at home. She stated she felt very bad once she got home and had no one to help her go to the bathroom. She added there was no food at her home. Resident #12 stated the facility told her that home health would be visiting her, so she would have what she needed once she got home. Resident #12 explained she had been home for several hours and could not get herself up to get on the toilet, so she called 911. She added she had felt bad all day, and no one had checked on her except to give her medications on the day she was discharged.

Pre phone interview on 1/27/19 at 2pm with a home health company staff member #1 revealed they had received a referral for Resident #12 from the facility on 12/13/18. The staff member stated the records she was looking at indicated the referral was denied and they provided no services for the resident in December 2018.

Pre phone interview with the medical doctor (MD) on 1/28/19 10:30am revealed that he last saw Resident #12 sometime in December. He stated the resident knew her medications and would be able to take her medication without assistance. The MD added we would need to talk to physical therapy about her transfer ability.

Pre phone interview with an APS worker on 1/28/19 at 11:00 am revealed he had received a call from the facility SW on 12/13/18 to let him know Resident #12 was being discharged home. The APS worker explained they were called in May 2018 about the condition of the resident's

and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 1/30/19. The education will involve the resident, resident□s representative if applicable and will include information such as post discharge services from home health agencies, Adult protective services (if applicable), Medication reconciliation, and will be documented on the each resident□s discharge records acknowledged by the resident and/or representative of their understanding. Any licensed nurse not educated by 1/30/19 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 1/30/19, and will also be provided annually.

The facility plans to monitor its performance to make sure that solutions are sustained.

Effective 1/30/19 the Facility Administrator, Director of Nursing, Assistant Director and/or Nursing, RN supervisors will review all planned discharges to the community in the next 72 hours to ensure that each resident receive sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that

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F 624	Continued From page 10 home. He added because the resident was placed in the nursing facility they had not been further involved with the resident's case. The APS worker explained the last communication he had with the facility SW was that Resident #12 was going to remain at the facility due to her health and didn't have any family to help take care of her. APS worker indicated that Resident #12 history indicated that someone need to clean up Resident #12's home before her return home. APS indicated that this information was indicated in Resident #12 history with APS. Review of statement from the Business office on 1/28/19 at 11:10am dated 10/10/2018 indicated that staff talked to resident she did not have a Medicaid application on file. Staff also explained to her that would be responsible for patient liability which consist of social security check minus $30.00. She completed her Medicaid application and told staff that she understood how it went: but did have any money to pay anything because she was paying for her trailer and other bills so she could go back home (however she paid 1,000.00 for October). An interview with Business Office Manager (BOM) on 1/28/2019 at 11:30am revealed she indicated that she went to see Resident #12 to pick up her monthly payment and Resident #12 indicated she was not paying anything here. BOM stated that Resident #12 told her to give her 30 day notice and Resident #12 indicated so she can go back home. Resident #12 stated "I owe everybody and other nursing facilities too and they are not getting anything either, what are they going to do: Nothing'. Resident #12 also stated that "she was not going to spend down her money nor give any information on her life	F 624	the resident understood before discharge from the facility. Any resident identified without sufficient education will be re-educated, staff member who provided education will be identified and re-educated to ensure adequate knowledge and skills on how to provide resident/resident□s representative education efficiently. Findings from this monitoring process will be documented on a daily Stand up report form and filed in stand up meeting binder after proper follow-ups are completed. The Facility Director of Nursing, Assistant Director of Nursing, Director of Service 1 or 2 will contact resident and/or representative, by phone, within seven days of discharge to check on resident to ensure the resident is safe at home. This monitoring process will take place daily for 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 1/30/19, Facility Administrator and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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insurance either."

An interview with facility SW #2 on 1/28/19 at 3:00 pm revealed she was a witness to the conversation on 7/6/2018 with the previous facility SW. She stated during this meeting the previous SW explained to Resident #12 that her last day of coverage would be 7/11/2018. Resident #12 stated during that meeting that she wanted to stay at the facility.

Pre phone interview on 1/29/19 at 10:45 am was conducted with the van driver from the transportation company that transported Resident #12 home. He stated he picked up the resident from the facility midday and transported her home. The van driver stated he did know the condition of her home. He explained he just "dropped her off and kept it moving".

Pre phone interview on 1/29/19 at 11:17 am with the facility Ombudsman revealed she was not aware of Resident #12's discharge. Ombudsman indicated he had not received any information on this resident's discharge.

An interview on 1/29/19 at 11:30 am with Nursing Aide (NA) #5 revealed she had provided care for Resident #12 when she was at the facility. She stated the resident was able to make her needs known. The resident would let the staff know if she needed to use the bedside commode, but the resident also choose to wear a brief. NA #5 added the resident required extensive one to two-person assistance with all her ADLs except she was able to feed herself.

An interview on 1/29/19 at 11:50 am with NA #2 revealed she was familiar with Resident #12 and

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that the resident had been discharged sometime in December. NA #2 explained she had worked with the resident on the day she was discharged, and the resident told her she would have an aide coming to help her when she got home. NA #2 stated the resident could do some for herself, but she was unsure if the resident would be able to clean herself up after having a bowel movement. She added the resident was able to make her needs known. NA #2 stated she had no knowledge if the facility hade made a home visit before the resident was discharged.

An interview on 1/29/19 at 1:00 pm with Nurse #2 revealed she had been the nurse for Resident #12 during her stay at the facility. She stated the resident didn't have any issues with taking her medications and that the resident had told her that when she was at home she had administered her own medications. Nurse #2 explained she discharged Resident #12 on 12/13/18 but she was unsure of the time. She added she had reviewed and instructed the resident on how to take her medications. She added the resident knew how to check her blood sugar and administer her insulin but stated she had never actually observed her doing this. Nurse #2 revealed she was not able to find the discharge paperwork for Resident #12.

Pre phone interview on 1/30/19 at 3:45 pm with a staff member #2 from a home health agency revealed the referral for services for Resident #12 was denied on 12/13/18. The staff member explained they had not received a referral from the facility but from a third party.

Pre phone interview with EMS Worker #1 on 1/31/19 at 11:00 am revealed he remembered

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Resident #12 and he had been at her home earlier in the year when the resident was stuck in the bathtub. He stated the resident lived in a trailer that had a horrible odor and was very "nasty". EMS Worker #1 added he didn't know how the resident even got around in her wheelchair because there was so much clutter. He explained when he responded to the call on 12/13/18 Resident #12 met them at the door. He added the resident would not let them in the house, but he could see that there was clutter, boxes and papers all over the floor and there was a horrible odor.

Pre phone interview on 1/31/19 at 12:38 pm with EMS Worker #2 revealed a call was received by 911 and dispatched to them as a sick call to Resident #12's home. Worker #2 indicated the resident had a history with EMS and they had observed the resident's home cluttered with trash up to the ceiling and the home had a very bad odor. He stated on this call the resident wouldn't let them in the house, but he could observe the clutter was still present. He explained they rolled the resident out of the home to her driveway and the fire department assisted them with getting the resident on a stretcher. Worker #2 indicated you could smell the odor from the house down to driveway. EMS Worker #2 added the resident was very weak and had urine and had stool on herself.

During a second interview with the Van Driver on 1/31/19 at 3pm VD indicated that it is not his responsibility to assess the Residents home but everyone knew that Resident #12's situation that he had to make a path in her house just to stack her boxes. VD also indicated that her home was clutter, nasty and had horrible odor.

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F 624	Continued From page 14 The Administrator was notified of immediate jeopardy on 1/30/2019 at 11:30am. The facility provided a credible allegation of compliance on 2/1/2019 at 10:52am. The credible allegation was amended on 3/1/19 to as follow: The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. As of 3/1/19 changes have been made to the original Allegation of Compliance that was accepted by the State survey team on 1/30/19. We are making these changes under the direction that CMS has requested the changes and we are assured that those changes will not impact the date the IJ was lifted for F 624. Date: 1/30/2019 Corrective action accomplished for those residents found to have been affected by the deficient practice. During the Survey the State alleged that; the facility failed to provide and document sufficient preparation and orientation to resident #12 to ensure safe and orderly discharge from the facility. The facility failed to train and orient the resident and or family representative on	F 624		

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administering medications, checking blood sugar and self-administration of insulin or any other medical treatment. The facility failed to have a discussion with the resident and or family representative to address the safety of the home environment in relation to the resident's physical condition and ability to maneuver at home, the resident's basic needs of food, water, electricity and heat and medical care needs. The facility failed to discuss with the resident and or family representative the level and type of support the resident needed from her family, significant others, the community, home health agencies, and any other government agencies and how the facility will assist the resident in getting the support and assistance she needed.
Resident #12 was given a 30 day notice on 11/15/2018 for nonpayment. Social Worker notes from 11/15/18 and 12/12/18 reflect discharge planning discussions with Resident #12 including that resident indicated she had family support at home.. On 12/13/18 Resident #12 was transferred home at her request by the facility with Home care services in place. Resident #12 was transferred to the hospital for generalized weakness on 12/13/2018 from her private home. At the time of the survey allegations it was identified that the resident was residing in another skilled nursing facility, no other corrective action was needed as a result of Resident #12's location.
On 1/30/19; Chief Clinical Officer from the Management and consulting company contracted by the facility, conducted the root cause analysis for this alleged noncompliance. The analysis concluded the alleged noncompliance resulted from the facility's failure to ensure that the facility management team that consist of the department supervisors understand the center's Abuse

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Prohibition and policies and procedures, specifically related to unsafe discharging of a resident that can be considered neglect.
Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
Audits of 100% of residents' discharge documentation in the last 90 days were completed by the Director of Nursing, assistant Director of nursing, Staff Development coordinator and/or unit manager on 1/30/19 to identify if any other resident was discharged without sufficient preparation and orientation to ensure safe and orderly discharge from the facility. This audit would have included identifying any involuntary discharge. No other resident was identified to be affected by this alleged noncompliance.
Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Effective 1/30/2019 the Director of Nursing, Director of Rehabilitation Center, Staff Development coordinator and/or Director of Social services will be responsible to initiate and train/provide the needed education to either resident and/or resident representative, or will train the designated licensed nurse who will then train the resident and/or resident representative. This education/training will take place at least three days before resident is discharged from the facility. Staff members who will be responsible to educate residents or resident's representative include; Director of Nursing, Director of Rehabilitation Center, Staff Development coordinator, Director of social services #1 or #2. And/or discharging nurse. The education will be intended to train and orient the resident and or

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family representative on the resident's medical care needs including but not limited to administering medications, checking blood sugar, self-administration of insulin or any other medical treatment. The facility will have a discussion with the resident and or family representative to address the resident's safety including but not limited to home environment in relation to the resident's physical condition and ability to maneuver at home, the resident's basic needs of food, water, electricity and heat and medical care needs or any other issues that are relevant to the safety of the resident. The facility will discuss with the resident and or family representative the level and type of support the resident needed from her family, significant others, the community, home health agencies, and any other government agencies and how the facility will assist the resident in getting the support and assistance she needed. The facility will discuss with the resident and or family representative any other issues the facility can help the resident to have a safe and orderly discharge as identified in the resident's discharge planning on the comprehensive care plan.
Effective 1/30/19 the facility will conduct a weekly "Case Management meeting" chaired by the facility Administrator, MDS nurse, Director of Rehabilitation and/or Director of Nursing. Residents with pending discharges will be discussed in this meeting at least a week in advance to allow the Director of Social Services #1 and/or #2 at least seven days to make necessary arrangements to ensure sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand. During this meeting the person who is going to orient the resident will be assigned.

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F 624	Continued From page 18 Effective 1/30/19 and moving forward the facility will conduct home visits as deemed appropriate and necessary by the facility licensed therapist and/or director of nursing to ensure resident's home is safe for the resident. Each resident will receive appropriate preparation, orientation and education individualized based on the findings from home visit before the discharge to ensure resident has a safe and orderly discharge. The education and home visits will be conducted prior to resident's discharge. The home visit will be documented on "the home visit checklist form" and maintained in resident's medical records. The facility will validate orientation was provided in a form and manner that the resident will understand. In the instance where the resident is unable to understand, resident's representative will be educated and/or Adult protective services will be notified effective 1/30/2019 Effective 1/30/19 the facility will conduct a discharge meeting and work with the resident and/or resident representative, if applicable, to develop interventions to meet each resident's discharge goals and to ensure a sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand. Any identified barriers will be addressed before the resident is discharged from the facility and hence reduce factors leading to preventable readmissions to the hospital. This review will take place daily Monday through Friday effective 1/30/19. Effective 1/30/2019 the director of social services will be ultimately responsible to coordinate all discharge meetings in the facility. The facility will not discharge any resident from the facility until the facility validates that all services are arranged and the resident is safe to be discharged effective 1/30/2019	F 624		

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Effective 1/30/19 and moving forward the facility director of social services #1 or #2 and/or discharging licensed nurse will provide and document sufficient preparation and orientation to residents and/or resident representative if applicable to ensure safe and orderly transfer or discharge. This orientation will be provided in a form and manner that the resident can understand. This education will be documented in resident's medical records.
Regional Clinical Consultant from the contracted Management and consulting company conducted re-education for current facility interdisciplinary team involved on discharge planning to include the Administrator, Director of Nursing, Director of Social services #1 and #2, Activity Director, Director of Rehabilitation services, MDS nurse and staff development coordinator on 1/30/19. This education emphasized on the importance of providing sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident's representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). This education will be completed by 1/30/19, any department head not educated by 1/30/19 will not be allowed to work until educated. Effective 1/30/19 this education will be added on new hires education and provided annually for all new facility department heads.
The Facility Director of Nursing (DON), Assistant Director of Nursing and/or staff development coordinator will complete 100% education on the importance of providing sufficient preparation and

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orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident's representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 1/30/19. The education will involve the resident, resident's representative if applicable and will include information such as post discharge services from home health agencies, Adult protective services (if applicable), Medication reconciliation, and will be documented on the each resident's discharge records acknowledged by the resident and/or representative of their understanding. Any licensed nurse not educated by 1/30/19 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 1/30/19, and will also be provided annually.

The facility plans to monitor its performance to make sure that solutions are sustained.

Effective 1/30/19 the Facility Administrator, Director of Nursing, Assistant Director and/or Nursing, RN supervisors will review all planned discharges to the community in the next 72 hours to ensure that each resident receive sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident understood before discharge from the facility. Any resident identified without sufficient education will be re-educated, staff member who provided education will be identified

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and re-educated to ensure adequate knowledge and skills on how toprovide resident/resident's representative education efficiently. Findings from this monitoring process will be documented on a daily "Stand up report" form and filed in "stand up meeting binder" after proper follow-ups are completed. The Facility Director of Nursing, Assistant Director of Nursing, Director of Service 1 or 2 will contact resident and/or representative, by phone, within seven days of discharge to check on resident to ensure the resident is safe at home. This monitoring process will take place daily for 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.
Effective 1/30/19, Facility Administrator and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

The title of the person responsible for implementing the acceptable plan of correction Effective 1/30/19 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.

Compliance Date 1/30/19.

This credible allegation was verified on 02/01/19 and as evidenced by the following: verification of re-education for licensed nurses of

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F 624	Continued From page 22 documentation for discharge of a resident including assessment, discharge begin at admission, discharge summary, medication release from and discharge instructions, validating the staff was reviewing resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge, education to the staff by the facility consultant regarding safe and orderly discharges for residents being given a 30-day discharge notice including documentation of discharge preparations, barriers, and resident status, facility to make home visits and education to the staff to contact the Ombudsman with all discharges.	F 624		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code falls on the Minimum Data Set (MDS) assessment tool. This was evident in 1 of 4 sampled residents reviewed for falls. (Resident #6) The findings included: Resident #6 was admitted to the facility on 8/24/18 with cumulative diagnoses which included muscle weakness, unspecified dementia with behavioral disturbance and cerebral vascular accident with right hand contracture. Review of the medical record revealed Resident	F 641	F641 Immediate Action: The MDS Assessment for #6 was reviewed and corrected on 2/20/19 to ensure Section J as it pertains to falls by the MDS nurse Identification of others affected: The MDS Nurse audited the last MDS assessment for all current residents on 2/20/19 to ensure the coding for Section J	2/20/19

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F 641	Continued From page 23 #6 experienced a fall on 9/2/18, 9/5/18, and 9/6/19 without injury. Review of the quarterly MDS dated 10/7/18 under J1800 (Any falls since admission/entry) was coded as zero (0) which represented no falls. Under section J1900 the MDS was not coded with the number of falls that occurred which resulted in no injuries. So, the resident's 3 documented falls since admission were not accurately noted on the 10/7/18 MDS. Interview on 1/25/19 at 10:30 AM with the Administrator and MDS coordinator was conducted. The MDS coordinator stated it was an oversight on her part. The administrator stated she expected that the MDS be accurate.	F 641	related to falls were correctly coded. Three assessments were found to have been coded incorrectly was corrected in section J for each of the three residents identified in the audit and re-submitted on 2/20/19 Systemic changes: Education was provided to the MDS Nurse by the Executive Director, which included the review of the medical record to be able to code Section J as it relates to falls on 2/20/19. Monitoring: The Director of Nursing will audit 10 completed MDS assessments weekly for four weeks then a sample of 10 or more MDS assessments for two months to ensure the coding of Section J pertaining to falls in Section J is coded correctly. These audits will be kept in a binder in the Executive Directors office. Findings will be reported to the QAPI Committee monthly for recommendations or modifications. If any negative findings are identified the Director of Nursing will continue to audit 10 completed MDS assessments weekly for four more weeks to establish a pattern of compliance is achieved. Any continuation of audits of completed MDS assessments done by the Director of Nursing will continue to be reported to the QAPI committee for further recommendations or modifications.	

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F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any	F 660		2/20/19

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F 660	Continued From page 25 referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with Adult Protective Services Worker, Medical Doctor, Ombudsman, Transportation Company	F 660	F 660 J Corrective action accomplished for those	

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F 660	Continued From page 26 Staff, Home Health Agency Worker, Emergency Medical Technician, former and current facility staff members and former resident the facility failed to provide 1 of 4 sampled residents (Resident #12) with a safe discharge planning process that included discharge goals, needs and caregiver support for Resident #12. The facility failed to assess Resident #12's medical condition and complete a home assessment to identify possible barriers for a safe discharge home. Immediate jeopardy began on 12/13/2018 when Resident #12 was transported to her home without any assessment, preparation, home assessment and caregiver in place. There was no evidence that the facility conducted a home evaluation before resident #12 was discharged on 12/13/18. Immediate Jeopardy was removed on 1/30/19 based on the allegation of compliance that was provided. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to training of facility staff regarding the discharge planning process. The Findings included: Resident #12 was admitted to the facility on 5/23/2018 with diagnoses that included heart failure, diabetes, chronic obstructive pulmonary disease, asthma, depression, neuropathy and muscle weakness. Review of the hospital discharge summary dated 5/23/18 revealed Resident #12 was found at home in her bathtub by Emergency Medical	F 660	residents found to have been affected by the deficient practice. Resident #12 was admitted on 5/23/2018 for short term rehabilitation services. Resident #12 received skilled nursing and rehabilitation services from 5/23/2018 up to 7/11/2018. Resident #12 was discharged from Medicare covered skilled services on 7/11/2018 after she met her therapy goals. Resident #12 remained in the facility after 7/11/2018 for custodial care without a payer source. On 10/10/2018, the facility Business Office Manager and Assistant Business Office Manager discuss with resident #12 regarding her failure to make payment arrangement for her stay in the facility. Resident #12 voiced the understanding of her financial obligation. On 11/15/2018; Business Office Manager provided resident #12 with the 30 □ days discharge notice since resident #12 failed, after reasonable and appropriate notice to pay for her stay at the facility. Resident #12 discharge date was set for 12/13/2018. On 12/13/2018, Resident #12 was discharged from the facility to her private home after the 30 days discharge notice expired. Facility arranged transportation to transport resident #12 to her private home via licensed non-emergency transportation company. Although resident #12 failed to pay for her stay at the facility, after reasonable and	

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F 660	Continued From page 27 Services (EMS). The patient reported she had called out for several days for help and her neighbors had called EMS because they had not heard from the patient for several days. EMS noted that the patient's home was "knee-deep" with trash that was full of rats and roaches. The patient was found to have a blood sugar of 690 milligrams per deciliter (mg/dl). Review of a social service progress note dated 5/29/18 for Resident #12 stated Adult Protective Services (APS) was working with the resident and identified the resident's home would need to be cleaned before she could return home. The resident planned to return home after she completed therapy, stabilized her medical condition and had her home cleaned. Review of a care plan for Resident #12 dated 6/15/18 revealed the resident desired to return home with a goal identified that she would return home with supportive services. Interventions included the facility would evaluate the resident's home for possible barriers, schedule a family meeting to discuss post change needs, assist the resident with obtaining community resources for discharge, notify the residents physician to discuss concerns and obtain orders for discharge supplies. Review of a social service progress note dated 7/6/18 for Resident #12 stated the Social Worker (SW) had informed the resident her last day of Medicare coverage was 7/11/18. The SW explained the non-coverage letter, advanced beneficiary notice letter and appeal process and rights to the resident. Resident #12 expressed to the SW that she was not ready to return home and may have to get her lawyer involved if the	F 660	appropriate notice was given, the state survey agency alleged that; the facility failed to ensure the post-discharge planned destination and continuing care was validated to meet resident #12 needs. Resident #12 was transferred to the hospital for generalized weakness on 12/13/2018 from her private home. Hospital records indicated resident #12 was unable to take care of herself at her home. Resident #12 is no longer in the facility, no further actions warranted at this time. On 1/30/19; Chief Clinical Officer from the Management and consulting company contracted by the facility, conducted the root cause analysis for this alleged noncompliance. The analysis concluded the alleged noncompliance resulted from the facility□s failure to implement a resident centered discharge process that should have started on admission; involved identifying resident #12 discharge goals and needs, and implementing interventions to address them; and continuously evaluating the discharge goals and needs throughout resident #12 stay that would have assured a safe and successful discharge. Discharge care plan for resident #12 indicated the facility will evaluate resident #12 home for possible barriers before discharge. There is no evidence that the facility conducted a home evaluation before resident #12 was discharged on 12/13/2018.	

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F 660	Continued From page 28 facility was going to throw her out. The SW explained to the resident that the facility was not throwing her out but providing this information per protocol and Medicare guidelines. After continued discussion with the resident she decided she would appeal the decision and a follow-up meeting was planned after notification of the appeal decision. Review of a quarterly Minimum Data Set (MDS) dated 11/15/18 for Resident #12 revealed her cognition was intact and an active discharge plan was in place for the resident to return to the community. She required extensive two-person assistance with bed mobility, transfers, personal hygiene and extensive one-person assistance with dressing, toilet use and bathing. She was incontinent of bowel and bladder. Review of MDS dated 11/15/2018 indicated that Resident #12's weight was 389 pounds and her height was 71 inches tall. Review of a transfer / discharge notice for Resident #12 dated 11/15/18 from the facility Administrator stated the date of discharge was 12/15/18. The reason for the transfer / discharge was Resident #12 after having received reasonable and appropriate notice failed to pay (or have paid under Medicare / Medicaid) for her stay at the facility. This information was given to Resident #12 and the Ombudsman on 11/15/2018. Review of a social service progress note dated 11/15/18 for Resident #12 stated discharge plans were discussed with the resident and she would like to discharge back to her home. The resident requested home health services upon discharge. The writer inquired about transfers as well as	F 660	Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. Audits of 100% of residents comprehensive care plan and/or baseline care plan were completed by the Minimum Data Set (MDS) nurse on 1/30/19 to identify whether a resident centered discharge plan was in place. The audit concluded there were no other residents identified without a resident centered care plan necessary to ensure safe and orderly discharge from the facility. 100% of comprehensive care plan and/or baseline care plan audits for all residents discharged to the community in the last 90 days were completed by the facility Director of Social Services #1 and/or #2 on 1/30/19 to identify any other resident discharged unsafely, and/or discharged without following a resident s discharge plan of care. There were no other residents identified as having an unsafe discharge in the last 90 days. The audit validated that each resident discharged from the facility to their private home in the last 90 days had a resident centered discharge planning in place and their discharge from the facility was safe and orderly except for resident #12. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not	

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F 660	Continued From page 29 assistance needed with toileting and the resident stated she would like continued supervision with her activities of daily living (ADLs) until discharge to ensure her balance and stability for transfers using the sliding board. The resident was currently working with therapy and the writer informed the therapy team of resident's request for assistance with transfers. The discharge paperwork was reviewed with the resident including her right to appeal. The resident stated appealing was a waste of time and she would like to go home. The writer would prepare the resident to return home and set up assistance closer to her discharge date. Review of a social services progress note dated 12/12/18 for Resident #12 stated discharge plans were reviewed again with the resident to ensure she was prepared for her transfer home on 12/13/18. The resident will discharge to her home per her choice. She was provided with options for independent living and assisted living facilities on numerous occasions, but the resident declined. The resident will transport home and receive home care services with the home health company of her choice. Her motorized wheelchair was in place as well as a bedside commode that was ordered by the facility. The resident expressed that her family and friends will assist her with the transition and check in on her periodically. There were no concerns brought to the attention of this writer by the resident. Review of the discharge summary for Resident #12 dated 12/12/18 at 1:19 pm revealed her physical home address, physicians name and number, discharge notes to the Ombudsman and home health services phone number and allergies with any adverse reactions. Attached to the discharge summary was a list of the	F 660	occur. Effective 1/30/19 each resident will have an individualized discharge care plan created on admission and become part of each resident□s comprehensive care plan. Each resident□s discharge care plan will be reviewed and revised at least quarterly and with significant change of resident condition by the facility MDS nurse or designated licensed nursing staff. The care plan revision will include, but not limited to, the inputs from the resident, resident representative, if applicable and/or interested family member as permitted by the resident. Effective 1/30/19 and moving forward all newly admitted resident have a care plan for discharge planning that include the following criteria□s; arranging and securing services (home health, adult protective services from other government agencies and the community. These items will be included in each resident□s individualized discharge care plan as appropriate. Effective 1/30/19 and moving forward the facility will conduct home visits as deemed appropriate and necessary by the facility licensed therapist and/or director of nursing to ensure resident□s home is safe for the resident. During the home visit the facility representative who is conducting the visit will make sure the resident have food, medicine and needed equipment□s necessary. These items will be included in each resident□s	

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F 660	Continued From page 30 residents' medications and her care plan. Review of a departmental note dated 12/13/18 for Resident #12 revealed the resident was alert and oriented, able to make needs know. No acute distress noted. The resident required assistance with ADLs, 2 person assist using mechanical lift with transfers. The resident took her meds without any problems, she was incontinent of bowel and bladder, breathing was even and unlabored. Blood sugar was checked, and insulin coverage provided. Review of a social service progress note dated 12/13/18 revealed APS was informed of the resident's choice to return home verses transfer to an independent or assisted living facility. Home health services were set up per request of the resident. The writer spoke with APS to alert case worker that the resident was being discharged home with home health services. Record review revealed Resident #12 was transported home on 12/13/18 2:30 pm by a transportation company that was paid for by the facility. An EMS report dated 12/13/18 7pm revealed EMS was dispatched to Resident #12's home for a sick call. A 63-year-old female complained of sitting in her motorized wheelchair. She reported she had been discharged home from the nursing home this afternoon after staying there for 7 months. She reported she arrived home about 2:00 pm today and was unable to transfer from her wheelchair to the toilet. The patient reported she was not able to complete her rehab while at the facility. Review of the hospital records dated 12/13/18 for	F 660	individualized discharge care plan as appropriate. The home visits will be conducted prior to resident□s discharge. The home visit will be documented on the home visit checklist form and maintained in resident□s medical records. Effective 1/30/2019 the facility will train the resident and/or family or significant other, regarding medication administration and/or any other procedures the resident needs before resident is discharged from the facility. This education will be documented in resident□s medical records by the facility director of social services #1 or #2 and/or discharging licensed nurse. Effective 1/30/19 the facility will conduct a weekly Case Management meeting chaired by the facility Administrator, MDS nurse, Director of Rehabilitation and/or Director of Nursing. Residents with pending discharges will be discussed in this meeting at least a week in advance to allow the Director of Social Services #1 and/or #2 at least seven days to make necessary arrangements so that the resident discharge was safe and orderly. Member of facility management will alert the interdisciplinary team during the daily stand up meeting for any resident with imminent discharge effective 1/30/2019. Effective 1/30/19 the facility will conduct a discharge meeting and work with the resident and/or resident representative, if applicable, to develop interventions to meet each resident□s discharge goals	

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F 660	Continued From page 31 Resident #12 identified her chief complaint was generalized weakness and unable to take care of herself. The patient had a history of atrial fibrillation, asthma, chronic kidney disease, chronic heart failure, depression, diabetes and hypertension. She had been at a skilled nursing facility for the past 7 months and was unable to take care of her bill, so she was discharged home this morning. She was unable to walk and used a motorized wheelchair. She had to go to the bathroom but was not able to get to the bedside commode, so she called EMS. EMS found the resident covered in urine and stool. The patient admitted to dysuria for the past couple days and a work up in the emergency room revealed a urinary tract infection and received 1 dose or Rocephin (an antibiotic). The patient was discharged from the hospital to a skilled nursing facility on 12/19/18. An interview with the former Social Worker (SW) on 1/25/19 at 11:00 am revealed she discharged Resident #12 on 12/13/2018. The SW indicated the resident wanted to go home and indicated she had neighbors to help her. The SW stated there were no family members present with the resident when she was discharged on 12/13/18. She added the facility arranged for the transportation company that took the resident home. She explained she had contacted APS and informed them that Resident #12 was being transferred home. The SW added that Resident #12 did not want to go to another facility and she only wanted to go home. An interview with the physical therapy staff member on 1/25/19 at 11:30 am revealed they had worked with Resident #12 prior to being discharged. The staff member stated the resident	F 660	and to ensure a smooth and safe transition from the facility to the post-discharge setting. The discharge meetings will be led by the facility□s Director of social services #1 and/or #2 and take place at least three days prior to resident is discharged from the facility, unless the resident stay is less than 3 days, effective 1/30/19. Any identified barriers will be addressed before the resident is discharged from the facility and hence reduce factors leading to preventable readmissions to the hospital. This review will take place daily Monday through Friday effective 1/30/19. Effective 1/30/2019 the director of social services will be ultimately responsible to coordinate all discharge meetings in the facility. The facility will not discharge any resident from the facility until the facility validates that all services are arranged and the resident is safe to be discharged effective 1/30/2019 Effective 1/30/19 and moving forward the facility will provide and document sufficient preparation and orientation to residents and/or resident representative if applicable to ensure safe and orderly transfer or discharge. This orientation will be provided in a form and manner that the resident can understand. This education will be documented in resident□s medical records by the facility director of social services #1 or #2 and/or discharging licensed nurse. Effective 1/30/19 and moving forward the	

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F 660	Continued From page 32 had not completed her goals and would not have been able to care for herself at home alone. She added Resident #12 would have had a hard time trying to transfer herself from her wheelchair to the toilet without assistance. An interview with Nursing Aide #1 (NA) on 1/25/19 at 11:45 am who worked with Resident #12 during her stay at the facility revealed the resident needed assistance with all her ADLs, however she could feed herself. NA # 1 added the resident wanted to go home. An interview with the Director of Nursing (DON) on 1/25/2019 at 11:00 am revealed she had no knowledge of Resident #12's discharge. An interview with the Administrator on 1/25/2019 at 1:00 pm revealed the SW completed the discharge for Resident #12 and she was unaware that the facility paid for this resident to be transported home. She stated she did not know if someone had made a home visit prior to Resident #12's discharge. Pre phone interview on 1/25/19 at 1:30 pm with a staff member of the skilled nursing facility that Resident #12 was currently residing at revealed the resident was admitted on 12/19/18 and required extensive to total assistance with her ADL's except she could feed herself with staff set-up. An interview with Resident #12 on 1/26/2019 at 2:00 pm revealed she was at the former facility for 8 months. She stated she told the facility she wanted to go home however she knew that she could not take care of herself. Resident #12 added the facility kicked her out because she had	F 660	facility□s administrative team, which includes Administrator, Director of nursing, Nurse supervisors, Director of Social Services #1 and #2, added the review of discharge process for all new admits to an existing process of reviewing new admits for the last 24 hours. By adding the review of residents□ discharge planning during daily department heads meetings, it will assure an effective discharge planning process that focuses on the resident□s discharge goals, prepare residents for effectively transition, and ensure post-discharge care is appropriately arranged. Effective 1/30/19 and moving forward the weekend Registered Nurse supervisor and/or designated licensed nurse will review new admissions for the last 24 hours to ensure that they have a discharge care plan in place developed on admission. This process with take place every Saturday and Sunday effective 1/30/19. The result of this systemic process will be documented on the weekend supervisor report form maintained in the Daily Stand up meeting binder. Findings from this systemic changes will be discussed in the daily □stand up meeting daily Monday through Friday effective 1/30/19 Regional Clinical Consultant from the contracted Management and consulting company conducted re-education for current facility interdisciplinary team involved on discharge planning to include the Administrator, Director of Nursing,	

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F 660	Continued From page 33 not paid them. She stated she had completed the Medicaid applications to get help but never but she never heard back. Resident #12 stated she did want to go home but with services in place. She added the facility knew she didn't have any family or support to help her at home. She stated she felt very bad once she got home and had no one to help her go to the bathroom. She added there was no food at her home. Resident #12 stated the facility told her that home health would be visiting her, so she would have what she needed once she got home. Resident #12 explained she had been home for several hours and could not get herself up to get on the toilet, so she called 911. She added she had felt bad all day, and no one had checked on her except to give her medications on the day she was discharged. Pre phone interview on 1/27/19 at 2pm with a home health company staff member #1 revealed they had received a referral for Resident #12 from the facility on 12/13/18. The staff member stated the records she was looking at indicated the referral was denied and they provided no services for the resident in December 2018. Pre phone interview with the medical doctor (MD) on 1/28/19 10:30am revealed that he last saw Resident #12 sometime in December. He stated the resident knew her medications and would be able to take her medication without assistance. The MD added we would need to talk to physical therapy about her transfer ability. Pre phone interview with an APS worker on 1/28/19 at 11:00 am revealed she had received a call from the facility SW on 12/13/18 to let her know Resident #12 was being discharged home.	F 660	Director of Social services #1 and #2, Activity Director, Director of Rehabilitation services, MDS nurse and staff development coordinator on 1/30/19. This education emphasized on the importance of developing, implementing, and evaluating each resident□s discharge planning at least 3 days before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident□s representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). The education will also include making sure each resident has an individualized discharge care plan created on admission; reviewed and revised at least quarterly and with significant change of resident condition; and at least 3 days prior to discharge to make sure the services are arranged and assured before the resident is discharged. The education also emphasized on the importance of assuring resident have food, medicine and needed equipment□s necessary. These items will be included in each resident□s individualized discharge care plan as appropriate. This education will be completed by 1/30/19, any department head not educated by 1/30/19 will not be allowed to work until educated. Effective 1/30/19 this education will be added on new hires education and provided annually for all new facility department heads. The Facility Director of Nursing (DON),	

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F 660	Continued From page 34 The APS worker explained they were called in May 2018 about the condition of the resident's home. He added because the resident was placed in the nursing facility they had not been further involved with the resident's case. The APS worker explained the last communication he had with the facility SW was that Resident #12 was going to remain at the facility due to her health and didn't have any family to help take care of her. Review of statement from the Business office on 1/28/19 at 11:10am dated 10/10/2018 indicated that staff talked to resident she did not have a Medicaid application on file. Staff also explained to her that would be responsible for patient liability which consist of social security check minus $30.00. She completed her Medicaid application and told staff that she understood how it went: but did have any money to pay anything because she was paying for her trailer and other bills so she could go back home (however she paid 1,000.00 for October). An interview with Business Office Manager (BOM) on 1/28/2019 at 11:30am revealed she indicated that she went to see Resident #12 to pick up her monthly payment and Resident #12 indicated she was not paying anything here. BOM stated that Resident #12 told her to give her 30 day notice and Resident #12 indicated so she can go back home. Resident #12 stated "I owe everybody and other nursing facilities too and they are not getting anything either, what are they going to do: Nothing'. Resident #12 also stated that "she was not going to spend down her money nor give any information on her life insurance either."	F 660	Assistant Director of Nursing and/or staff development coordinator will complete 100% education on the importance of developing discharge planning beginning on admission and completed immediately and/or within 48 hours of admission. This education emphasized the documentation requirements for all residents discharged to the community to include but no limited to physician orders, discharge education, and interdisciplinary team discussion. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 1/30/19. The education will involve the resident, resident□s representative if applicable and will include information such as post discharge services from home health agencies, Adult protective services (if applicable), Medication reconciliation, and will be documented on the each resident□s discharge records acknowledged by the resident and/or representative of their understanding. Any licensed nurse not educated by 1/30/19 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 1/30/19, and will also be provided annually. The facility plans to monitor its performance to make sure that solutions are sustained.	

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F 660	Continued From page 35 An interview with facility SW #2 on 1/28/19 at 3:00 pm revealed she was a witness to the conversation on 7/6/2018 with the previous facility SW. She stated during this meeting the previous SW explained to Resident #12 that her last day of coverage would be 7/11/2018. Resident #12 stated during that meeting that she wanted to stay at the facility. Pre phone interview on 1/29/19 at 10:45 am was conducted with the van driver from the transportation company that transported Resident #12 home. He stated he picked up the resident from the facility midday and transported her home. The van driver stated he did know the condition of her home. He explained he just "dropped her off and kept it moving". Pre phone interview on 1/29/19 at 11:17 am with the facility Ombudsman revealed she was not aware of Resident #12's discharge. An interview on 1/29/19 at 11:30 am with Nursing Aide (NA) #5 revealed she had provided care for Resident #12 when she was at the facility. She stated the resident was able to make her needs known. The resident would let the staff know if she needed to use the bedside commode, but the resident also choose to wear a brief. NA #5 added the resident required extensive one to two-person assistance with all her ADLs except she was able to feed herself. An interview on 1/29/19 at 11:50 am with NA #2 revealed she was familiar with Resident #12 and that the resident had been discharged sometime in December. NA #2 explained she had worked with the resident on the day she was discharged, and the resident told her she would have an aide coming to help her when she got home. NA #2	F 660	Effective 1/30/19 the Facility Administrator, Director of Nursing, Assistant Director and/or Nursing, RN supervisors will review all planned discharges to the community in the last 24 hours to ensure that each resident□s discharge goals and plan of care was implemented appropriately. (This review is intended to evaluate the systemic changes implemented that discuss resident□s discharges at least three days prior to discharge). Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily Stand up report form and filed in stand up meeting binder after proper follow-ups are completed. This monitoring process will take place daily for 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 1/30/19, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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stated the resident could do some for herself, but she was unsure if the resident would be able to clean herself up after having a bowel movement. She added the resident was able to make her needs known. NA #2 stated she had no knowledge if the facility hade made a home visit before the resident was discharged.

An interview on 1/29/19 at 1:00 pm with Nurse #2 revealed she had been the nurse for Resident #12 during her stay at the facility. She stated the resident didn't have any issues with taking her medications and that the resident had told her that when she was at home she had administered her own medications. Nurse #2 explained she discharged Resident #12 on 12/13/18 but she was unsure of the time. She added she had reviewed and instructed the resident on how to take her medications. She added the resident knew how to check her blood sugar and administer her insulin but stated she had never actually observed her doing this. Nurse #2 revealed she was not able to find the discharge paperwork for Resident #12.

Pre phone interview on 1/30/19 at 3:45 pm with a staff member #2 from a home health agency revealed the referral for services for Resident #12 was denied on 12/13/18. The staff member explained they had not received a referral from the facility but from a third party.

Pre phone interview with EMS Worker #1 on 1/31/19 at 11:00 am revealed he remembered Resident #12 and he had been at her home earlier in the year when the resident was stuck in the bathtub. He stated the resident lived in a trailer that had a horrible odor and was very "nasty". EMS Worker #1 added he didn't know

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how the resident even got around in her wheelchair because there was so much clutter. He explained when he responded to the call on 12/13/18 Resident #12 met them at the door. He added the resident would not let them in the house, but he could see that there was clutter, boxes and papers all over the floor and there was a horrible odor.

Pre phone interview on 1/31/19 at 12:38 pm with EMS Worker #2 revealed a call was received by 911 and dispatched to them as a sick call to Resident #12's home. Worker #2 indicated the resident had a history with EMS and they had observed the resident's home cluttered with trash up to the ceiling and the home had a very bad odor. He stated on this call the resident wouldn't let them in the house, but he could observe the clutter was still present. He explained they rolled the resident out of the home to her driveway and the fire department assisted them with getting the resident on a stretcher. Worker #2 indicated you could smell the odor from the house down to driveway. EMS Worker #2 added the resident was very weak and had urine and had stool on herself.

During a second interview with the Van Driver on 1/31/19 at 3pm VD indicated that it is not his responsibility to assess the Residents home but everyone knew that Resident #12's situation that he had to make a path in her house just to stack her boxes. VD also indicated that her home was clutter, nasty and had horrible odor.

The Administrator was notified of immediate jeopardy on 1/28/2019 at 1:32pm

The facility provided a credible allegation of

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compliance on 1/30/2019 at 6pm. The credible allegation was amended on 3/1/19 to as follow:

The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

As of 3/1/19 changes have been made to the original Allegation of Compliance that was accepted by the State survey team on 1/30/19. We are making these changes under the direction that CMS has requested the changes and we are assured that those changes will not impact the date the IJ was lifted for F 660.

Date: 1/30/2019
Corrective action accomplished for those residents found to have been affected by the deficient practice.
During the Survey the State alleged that the facility failed to ensure the post-discharge planned destination and continuing care was validated to meet resident #12 needs. Resident #12 was transferred to the hospital for generalized weakness on 12/13/2018 from her private home. Hospital records indicated resident #12 was unable to take care of herself at her home. Resident #12 is no longer in the facility, no further actions warranted at this time.
Resident #12 was given a 30 day notice on 11/15/2018 for nonpayment. Social Worker notes

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from 11/15/18 and 12/12/18 reflect discharge planning discussions with Resident #12 including that resident indicated she had family support at home.. On 12/13/18 Resident #12 was transferred home at her request by the facility with Home care services in place. Resident #12 was transferred to the hospital for generalized weakness on 12/13/2018 from her private home. At the time of the survey allegations it was identified that the resident was residing in another skilled nursing facility, no other corrective action was needed as a result of Resident #12's location.
On 1/30/19; Chief Clinical Officer from the Management and consulting company contracted by the facility, conducted the root cause analysis for this alleged noncompliance. The analysis concluded the alleged noncompliance resulted from the facility's failure to ensure that the facility management team that consist of the department supervisors understand the center's Abuse Prohibition and policies and procedures, specifically related to unsafe discharging of a resident that can be considered neglect.
Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
Audits of 100% of residents' comprehensive care plan and/or baseline care plan were completed by the Minimum Data Set (MDS) nurse on 1/30/19 to identify whether a resident centered discharge plan was in place. The audit concluded there were no other residents identified without a resident centered care plan necessary to ensure safe and orderly discharge from the facility.

100% of comprehensive care plan and/or baseline care plan audits for all residents

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discharged to the community in the last 90 days were completed by the facility Director of Social Services #1 and/or #2 on 1/30/19 to identify any other resident discharged unsafely, and/or discharged without following a resident's discharge plan of care. There were no other residents identified as having an unsafe discharge in the last 90 days. The audit validated that each resident discharged from the facility to their private home in the last 90 days had a resident centered discharge planning in place and their discharge from the facility was safe and orderly except for resident #12.

Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Effective 1/30/19 each resident will have an individualized discharge care plan created on admission and become part of each resident's comprehensive care plan. Each resident's discharge care plan will be reviewed and revised at least quarterly and with significant change of resident condition by the facility MDS nurse or designated licensed nursing staff. The care plan revision will include, but not limited to, the inputs from the resident, resident representative, if applicable and/or interested family member as permitted by the resident.
Effective 1/30/19 and moving forward all newly admitted resident have a care plan for discharge planning that include the following criteria's; arranging and securing services (home health, adult protective services from other government agencies and the community. These items will be included in each resident's individualized discharge care plan as appropriate.
Effective 1/30/19 and moving forward the facility will conduct home visits as deemed appropriate

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and necessary by the facility licensed therapist and/or director of nursing to ensure resident's home is safe for the resident. During the home visit the facility representative who is conducting the visit will make sure the resident have food, medicine and needed equipment's necessary. These items will be included in each resident's individualized discharge care plan as appropriate. The home visits will be conducted prior to resident's discharge. The home visit will be documented on "the home visit checklist form" and maintained in resident's medical records.
Effective 1/30/2019 the facility will train the resident and/or family or significant other, regarding medication administration and/or any other procedures the resident needs before resident is discharged from the facility. This education will be documented in resident's medical records by the facility director of social services #1 or #2 and/or discharging licensed nurse.
Effective 1/30/19 the facility will conduct a weekly "Case Management meeting" chaired by the facility Administrator, MDS nurse, Director of Rehabilitation and/or Director of Nursing. Residents with pending discharges will be discussed in this meeting at least a week in advance to allow the Director of Social Services #1 and/or #2 at least seven days to make necessary arrangements so that the resident discharge was safe and orderly. Member of facility management will alert the interdisciplinary team during the daily "stand up meeting" for any resident with imminent discharge effective 1/30/2019.
Effective 1/30/19 the facility will conduct a discharge meeting and work with the resident and/or resident representative, if applicable, to develop interventions to meet each resident's

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discharge goals and to ensure a smooth and safe transition from the facility to the post-discharge setting. The discharge meetings will be led by the facility's Director of social services #1 and/or #2 and take place at least three days prior to resident is discharged from the facility, unless the resident stay is less than 3 days, effective 1/30/19. Any identified barriers will be addressed before the resident is discharged from the facility and hence reduce factors leading to preventable readmissions to the hospital. This review will take place daily Monday through Friday effective 1/30/19.

Effective 1/30/2019 the director of social services will be ultimately responsible to coordinate all discharge meetings in the facility. The facility will not discharge any resident from the facility until the facility validates that all services are arranged and the resident is safe to be discharged effective 1/30/2019

Effective 1/30/19 and moving forward the facility will provide and document sufficient preparation and orientation to residents and/or resident representative if applicable to ensure safe and orderly transfer or discharge. This orientation will be provided in a form and manner that the resident can understand. This education will be documented in resident's medical records by the facility director of social services #1 or #2 and/or discharging licensed nurse.
Effective 1/30/19 and moving forward the facility's administrative team, which includes Administrator, Director of nursing, Nurse supervisors, Director of Social Services #1 and #2, added the review of discharge process for all new admits to an existing process of reviewing new admits for the last 24 hours. By adding the

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review of residents' discharge planning during daily department heads meetings, it will assure an effective discharge planning process that focuses on the resident's discharge goals, prepare residents for effectively transition, and ensure post-discharge care is appropriately arranged.
Effective 1/30/19 and moving forward the weekend Registered Nurse supervisor and/or designated licensed nurse will review new admissions for the last 24 hours to ensure that they have a discharge care plan in place developed on admission. This process with take place every Saturday and Sunday effective 1/30/19. The result of this systemic process will be documented on the weekend supervisor report form maintained in the "Daily Stand up meeting binder. Findings from this systemic changes will be discussed in the daily 'stand up meeting" daily Monday through Friday effective 1/30/19
Regional Clinical Consultant from the contracted Management and consulting company conducted re-education for current facility interdisciplinary team involved on discharge planning to include the Administrator, Director of Nursing, Director of Social services #1 and #2, Activity Director, Director of Rehabilitation services, MDS nurse and staff development coordinator on 1/30/19. This education emphasized on the importance of developing, implementing, and evaluating each resident's discharge planning at least 3 days before discharge to ensure each resident have a safe discharge from the facility. The education will involve the resident, resident's representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective services (if applicable). The education will also include making sure each resident has an individualized

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discharge care plan created on admission; reviewed and revised at least quarterly and with significant change of resident condition; and at least 3 days prior to discharge to make sure the services are arranged and assured before the resident is discharged. The education also emphasized on the importance of assuring resident have food, medicine and needed equipment's necessary. These items will be included in each resident's individualized discharge care plan as appropriate. This education will be completed by 1/30/19, any department head not educated by 1/30/19 will not be allowed to work until educated. Effective 1/30/19 this education will be added on new hires education and provided annually for all new facility department heads.

The Facility Director of Nursing (DON), Assistant Director of Nursing and/or staff development coordinator will complete 100% education on the importance of developing discharge planning beginning on admission and completed immediately and/or within 48 hours of admission. This education emphasized the documentation requirements for all residents discharged to the community to include but no limited to physician orders, discharge education, and interdisciplinary team discussion. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 1/30/19. The education will involve the resident, resident's representative if applicable and will include information such as post discharge services from home health agencies, Adult protective services (if applicable), Medication reconciliation, and will be documented on the each resident's discharge records acknowledged by the resident and/or

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representative of their understanding.
Any licensed nurse not educated by 1/30/19 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 1/30/19, and will also be provided annually.
The facility plans to monitor its performance to make sure that solutions are sustained.
Effective 1/30/19 the Facility Administrator, Director of Nursing, Assistant Director and/or Nursing, RN supervisors will review all planned discharges to the community in the last 24 hours to ensure that each resident's discharge goals and plan of care was implemented appropriately. (This review is intended to evaluate the systemic changes implemented that discuss resident's discharges at least three days prior to discharge). Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily "Stand up report" form and filed in "stand up meeting binder" after proper follow-ups are completed. This monitoring process will take place daily for 4 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.
Effective 1/30/19, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assuranceand Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

The title of the person responsible for

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F 660	Continued From page 46 implementing the acceptable plan of correction Effective 1/30/19 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance. Compliance Date 1/30/19 The credible allegation was verified on 02/01/19 and as evidenced by the following: verification of re-education for licensed nurses of documentation for discharge of a resident including assessment, discharge begin at admission, discharge summary, medication release from and discharge instructions, validating the staff was reviewing resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge, education to the staff by the facility consultant regarding safe and orderly discharges for residents being given a 30-day discharge notice including documentation of discharge preparations, barriers, and resident status, facility to make home visits and education to the staff to contact the Ombudsman with all discharges.	F 660		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		2/18/19

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F 689	Continued From page 47 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician (MD) interview, the facility failed to provide supervision to prevent a totally dependent resident from falling out of bed for 1 of 4 sampled residents reviewed for accidents. Resident #13 fell out of bed which was in the high position when the staff member left the resident unattended in bed. Additionally, the staff member moved the resident from the floor back to bed by herself before the resident was assessed for any injuries. As a result of the fall, the resident sustained large bruises from right rib mid back down across right buttocks and skin tear on right middle buttock. Resident #13 expired later the same day of the fall. Findings included: Resident #13 was readmitted in the facility on 8/10/17 with a diagnosis of multifocal cerebral vascular accident, acute encephalopathy, hypertension, Alzheimer's disease, dysphagia, aphasia and acute kidney injury. The resident had a gastrostomy (stomach) tube placed for her nutrition, fluids and medications. The Minimum Data Set (MDS) dated 11/8/18 indicated the resident was severely cognitively impaired and stated that the resident cannot communicate her needs or had no ability to make herself be understood. It was coded that the resident needed extensive assistance with bed mobility, transfer and dressing with two person assistance. The care plan for Resident #13 last updated by	F 689	Past noncompliance: no plan of correction required.	

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the facility on 11/2/18 was reviewed. The resident required a total assistance with Activities of Daily Living (ADL). The goal was to have no evidence for further ADL decline through the next review. The approaches included extensive to total care for aspects of ADL.

The Hospice Nurse visiting notes from 12/24/18 to 1/14/19 showed no changes from the previous months. There were no signs of any respiratory issues for the resident and the resident needed no oxygen (O2) treatment. The O2 saturation (O2 Sat - (blood oxygen level)) from the assessment ranges from 95% to 99% with room air (Normal range is 94% to 99%). There was no skin bruising noted in their assessments.

An investigation report for the incident written on 1/16/19 at 11:15 AM by the Administrator stated the Nursing Assistant (NA) #1 was providing care on 1/15/19 and raised the resident's bed. NA#1 turned the resident on her side and stepped away from the bed, to the door to alert the nurse of a status change regarding the resident's eye. When NA #1 turned her back she heard a noise. And when she turned around the resident was on the floor, she ran to the door again to get the nurse. She was unable to locate the nurse and turned around back in the room and felt the resident was uncomfortable on the floor because the resident was tangled in the feeding tube and catheter. The Administrator's report further stated that the resident fell out of bed from a high position. The NA panicked, lowered the bed, pulled the resident back to bed. After putting the resident to bed, the NA ran out and got the nurse.

Several phone calls were attempted to NA #1 during the survey but these attempts were

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unsuccessful to conduct an interview with her.

A nurses' notes on 1/15/19 written by Nurse #1 revealed that NA #1 called the nurse to the room of Resident #13 at 11:30 AM. The NA showed the nurse some bruises on the resident's right side. The note stated that there was a skin tear and scratch on resident's right buttocks area with some discoloration on right side of the rib cage.

An interview with Nurse #1 was conducted on 2/1/19 at 10:40 AM. The nurse stated that on 1/15/19 she immediately notified unit supervisor and the Assistant Director of Nursing (ADON) of the bruising and skin tear. Nurse #1 also notified the family member, the hospice nurse and the Medical Doctor (MD) of the bruising and skin tear. The MD ordered chest x-ray and monitoring the resident for any distress. She further stated that the family member came to the facility and stayed with the resident. The chest x-ray was never performed due to the resident's passing away later that day.

Another interview with Nurse #1 on 2/1/19 at 2:14 PM she stated she assessed the resident when she was called in the room at 11:30 AM on 1/15/19 including monitoring her vital signs which were within normal limits and the resident's respiration increased with signs of anxiety. She stated that an Ativan 0.5mg was given as requested by the family member and to help the resident calm down. Nurse #1 also stated that NA #1 originally denied any knowledge of what caused the bruises from the resident. Nurse #1 also stated the bruising on the right rib and right buttock were like a hand/finger marks. The nurse stated that NA #1 came back about 30 minutes later and admitted that she knew what had

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happened to the resident. The NA revealed that she walked away from the resident while doing morning care to get the nurse to assess resident's eye and when she turned around, the resident was sliding off the bed. The NA stated that she intercepted the fall. Nurse #1 stated that the resident was monitored for any distress several times on 01/15/19 to make sure the resident was in stable condition. She stated that the resident was resting in bed and the family member was in the room the whole time. The nurse said they didn't do a neuro checks because there was no report at that time that the resident fell out of bed and there were no signs of any head injury. The family member was there so they checked the resident visually for any distress.

A hospice nurses' notes on 1/15/19 at 5:37 PM indicated a large hematoma extending from right mid back down across the flank. An abrasion on the right buttock was also written in her assessment.

An interview with the Hospice Nurse was conducted on 2/1/19 at 3:41 PM. The Hospice Nurse stated that she observed Resident # 13 on 1/15/19. She explained that the resident's hematoma (bruise) was located at the right mid rib and flank down to her right buttock. She stated that there was also an abrasion in the resident's right middle buttock.

A nurses' notes on 1/15/19 at 7:04 PM written by the ADON indicated the resident went on distress at 2:40 PM and the O2 saturation recorded was at 60% and the pulse rate was 76 Beats Per Minute (BPM) (Normal pulse rate is 60 to 100). The note indicated that the head of the bed was

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elevated, and O2 was started at 5 liters per minute via a face mask. The O2 Sat was rechecked after 15 minutes and it went up to 78% after the continuous O2 treatment. She stated in the note that the MD and the Hospice Nurse was notified right around 2:40 PM.

The Hospice Nurse stated during her interview on 2/1/19 at 3:41 PM that she came in the door after 3:00 PM and saw the resident in bed with her head of the bed in high position with oxygen mask. The Hospice Nurse stated that the resident already expired when she got in the resident's room. She further stated that she pronounced the resident expired at 3:45 PM.

The ADON was interviewed on 2/1/ 19 at 11:35 AM. She stated that NA #1 confessed the following day on 1/16/19 with the facility administration that the resident rolled out of bed to the floor during her ADL care. The NA admitted that she assisted the resident to bed alone without alerting the nurse of the fall.

An interview with a Nursing Assistant (NA) #4 was conducted on 2/1/19 at 9:45 AM. The NA stated that the resident was a total care and the resident was unable to move by herself due to her contractures of her hands and her legs. NA #4 stated that Resident #13 was very stiff and solid that needed two persons assist with ADL care.

NA #3 was interviewed on 2/1/19 at 2:44 PM and she stated Resident #13 cannot move herself independently and the resident needed two persons assist during ADL care.

An interview with Nurse #1 was conducted on 2/1/19 at 10:40 AM. The Nurse stated the

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resident had contractures on her upper and lower extremities. She also stated the resident cannot move by herself and the resident was somewhat in fetal position all the time. Nurse #1 also stated the resident only open her eyes with verbal stimulation and moans at times.

Interview with the Unit Coordinator on 2/1/19 at 11:17 AM she stated the resident needed 2 persons assist with bed mobility and transfers.

Interview with the ADON on 2/1/19 at 11:35 AM the ADON stated that the resident needed 2 persons assist with bed mobility and transfers.

Interview with MDS Coordinator on 2/1/19 at 3:15 PM she stated that the resident needed 2 persons assist with bed mobility and transfers.

Interview with the MD was conducted on 2/1/19 at 4:01 PM. The MD stated that the resident was with no brain function and on hospice for her declining health status. He stated the hospice was ordered for the resident who could die in the next 6 months. The MD did not know about the fall up until the next day on 1/16/18 when he was informed by the facility staff. The MD stated that he didn't believe the fall caused the death of the resident. The MD stated that the order to monitor was for any distress the resident might have.

Review of the resident's death certificate indicated the resident died of vascular Dementia, cerebrovascular disease and adult failure to thrive.

An interview with the Chief Clinical Officer (CCO) was conducted on 2/1/19 at 4:35 PM. The CCO stated that they have investigated this incident

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and the NA no longer worked for the company. The written investigation showed by the CCO specified that on 01/15/19 at 11:30 AM, NA #1 left Resident #13 unattended while positioned on the side of the bed with the bed in the high position and resident fell from bed to the floor and experienced injuries which included bruising from her right mid ribs down to her right buttocks. Skin tear was also noted on the right buttocks. He also stated that they implemented a corrective action plan for this incident and provided a binder for their plan of correction.

The facility plan of correction:
The facility provided the following plan of corrections that had been completed on 1/19/19.

Corrective action accomplished for those residents found to have been affected by the deficient practice.
Resident #13 was admitted to the facility on 07/07/2017 for long term care services. On 7/27/2018 resident #13 was admitted on Hospice services while in the facility and coded on section "O" of MDS with ARD 11/1/2018. Review of facility most recent minimum data set, with Assessment reference date 11/1/2018 section G indicated Resident #13 requires extensive assistance with bed mobility with two assists, transfer with one assistance, and toileting with one assistance. Resident #13 coded in section J. to have no falls since the entry/re-entry and/or last assessment. Review of fall incident log from 7/7/2017 up to 1/15/2019 indicated Resident #13 had one fall dated 1/15/2019.

On 1/15/2019 during AM care resident #13 rolled off the bed onto the floor. The nursing aide providing care had turned the resident on her side

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and stepped to the door to alert the nurse of a status charge regarding's right eye. Before the nursing aide exited the room, resident #13 fell from bed to the floor while the bed was in high position.

C.N.A. failed to report timely and accurately. C.N.A. failed to lower bed to lowest position prior to leaving bed side. C.N.A moved resident before resident was assessment by a licensed nurse. C.N.A. failed to position resident properly and safely on the bed. Nurse aide #1 assisted resident from the floor back to bed without alerting a nurse to assess the resident which is contrary to the facility standards and expectation. Nurse aide number one then exited the room and notified a nurse of the right ribs discoloration and right buttock skin tear with a scratch and claimed that she noticed those injuries when she was turning resident #13 in bed. Nurse aide #1 also reported to licensed nurse #1 the discoloration Licensed nurse #1 walked to resident room and assessed the resident while in bed and noticed right rib discoloration and right buttock skin tear a scratch. Licensed nurse #1 notified unit supervisor who walked to resident's room with the licensed nurse #1 and reassessed resident #13. Unit supervisor indicated that resident shown no signs or symptoms of destress. Nurse aide #1 who was providing care for resident #13 was suspended on 1/15/2019 pending investigation as she did not report resident fall. Attending physician, attending physician called the facility within 30 minutes and ordered X-rays to be completed.

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient

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practice.
100% of residents care cards audit completed on 1/18/2018 by the facility unit manager #1 and Unit manager #2 to ensure each resident means of transfer is documented in a care card. Any resident identified without directives was re-assessed and means of transfer added on the care. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Effective 1/19/2019 nursing assistants will review resident's care card before providing care for any resident to ensure appropriate number of staff is used during ADL care as indicated on each resident's care card. Nursing assistants will utilize the appropriate number of staff during care and hence ensure resident safety.

Effective 1/19/2019 nursing assistants will not move any resident from the floor when a resident experience any fall until the resident is assessed by the trained personnel, specifically licensed nurses. Nursing assistant should make all attempts possible to make resident comfortable while waiting for assistance to arrive.

Facility Administrator, and/or Director of Nursing conducted re-education for current nursing assistants' onsite on 1/19/2019. This education included, importance of ensuring resident is not moved from the floor until proper assessments are completed by the appropriate, trained personnel (licensed nurse) and the importance of following resident's level of assistance needed by reviewing each resident's care cards. This education will be completed by 1/19/2019, any nursing assistant not educated by 1/19/2019 will not be allowed to work until educated on this requirement. Effective 1/19/2019 this education

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will be added on new hires orientation education for all new facility nursing assistants. This education will also be provided annually for all facility staff to include nursing assistants.

The facility plans to monitor its performance to make sure that solutions are sustained. Effective 1/19/2019 the Director of Nursing (DON), Assistant Director of Nursing (ADON), RN supervisors and/or Staff Development Coordinator (SDC) initiated a process to review residents' transfer capabilities on admission/readmission and/or with resident's change of condition and update resident's care card immediately. By updating the care card, it will ensure each resident has a correct transfer method in place and hence receive appropriate services to attain and maintain highest practicable wellbeing.

Effective 01/19/19, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor the accuracy and updates of each resident's care card by conducting clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, any admission/readmission occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting, and validated whether resident's care card was updated . Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report daily (M-F) X4 weeks, weekly x 4 weeks, then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(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 689	Continued From page 57 monthly x 3 months. Effective 01/19/19, Residents will be audited after ADL care bed is in the lowest position and resident is positioned correctly and safely in bed. DON/ADON/Unit Managers,3-11 Supervisor and Weekend Supervisor. Audits will include 15 residents daily x 2 weeks, 5 days x 1 weeks, and monthly x 3 months Effective 01/19/19, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. The title of the person responsible for implementing the acceptable plan of correction. Effective 1/19/2019 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance. On 2/1/19 at 5:48 PM, the plan of correction of the facility was validated. The survey team confirmed the facility addressed the resident involved and acted to mitigate the risk of the other residents. The facility re-educated all staff of safety transfers and the education included the policy to call and report to the nurse for assessment before moving any resident from fall. The facility implemented an audit to update all care card. The facility initiated a process to review resident's transfer capabilities and update the care card of all residents including the new	F 689		

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F 689	Continued From page 58 admission. The facility also implemented the monitoring process and to be included in the Quality Assurance and Performance Improvement Committee meeting. The facility's plan of date of correction of 1/19/2019 was validated.	F 689		