STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted from 02/20/23 through 02/21/23. Event ID# W0Z611 1 of the 4 complaint allegations resulted in a deficiency. NC 00198355 NC 00196480	F 000		
F 660 SS=D	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	F 660		3/17/23

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

Electronically Signed | 03/09/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 660	Continued From page 1	F 660		

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 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

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F 660	Continued From page 2 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 review, and Nurse Practitioner, staff and family interview the facility failed to implement and follow through with an effective discharge process for 1 of 1 resident discharged (Resident #1). The facility failed to provide a printed medication list and discharge instructions to the resident or the Responsible Party for 1 of 1 resident reviewed for discharge. Findings included: Resident # 1 was admitted to the facility on 12/16/22. Her diagnoses included a recent history of pneumonia, rheumatoid arthritis, hypertension, and muscle weakness. Resident #1 was discharged home on 01/17/23. The discharge form titled Medical Discharge Summary dated for Resident #1 indicated her intended discharge date would be 01/13/23. The Nurse Practitioner had a note dated 01/12/23; the note documented after the resident's planned discharge (1/13/23) the resident should follow up with her primary care provider in 1-2 days and this was discussed with the patient on 01/12/23. The note further documented the resident was not in acute distress, her lungs were clear, and she had normal respiratory effort. The resident was not discharged until 1/17/23 and the above document was not updated to reflect the change in the discharge date.	F 660	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. F660 Deficient practice identification and corrective action for resident found to have been affected by this deficient practice • Deficient practice: The facility failed to follow through with and implement an effective discharge practice for resident #1 by not providing appropriate written discharge instructions and medication list to the resident/ Responsible Party on the day of discharge per family. • Corrective action: medical records provided to the family with all appropriate information and follow-up with home health initiated to ensure they were meeting the recommended needs of the	

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F 660	Continued From page 3 Record review indicated the Discharge Instructions/Post Discharge Plan of Care for Resident #1 form was signed by the SW on 01/16/23. The section for "given to" was not signed or dated by the resident or RP in the designated spaces. The nursing section was not completed, the following sections were left blank: - the follow up physician appointment information -Resident Medical Information -Nursing Post-Discharge Plan for Care -Nebulizer Therapy information (family picked up nebulizer from medical supply company 01/17/23) -Patient Education Provided -Include copy of medications (Medication/Treatment List) -Prescriptions given to patient or called into Pharmacy - Medications sent home with resident The Discharge Minimum Data Set assessment for Resident #1, dated 01/17/23 indicated the resident was cognitively intact. Resident # 1's family member who was her primary caregiver was interviewed via phone on 02/20/23 and reported the following: - The facility contacted the family member for payment for services on 02/08/23 and Resident #1's caregiver informed the facility that no home health services had been provided and they had received no calls from a home health agency after discharge for Occupational Therapy, Physical Therapy, or Nursing visits as per the discharge plan shared with her via phone by the Social Worker - There was no discharge paperwork provided at the time of discharge other than 11 prescriptions. There	F 660	patient now How will the facility identify other residents that have the potential to be affected by the same deficient practice: • An audit of all discharges from February 22nd to March 6th , 2023 was completed by March 10th to ensure all appropriate documentation needed for a safe and effective discharge was provided to the resident and/or responsible party as indicated by all sections of discharge summery being complete and signed by the resident/responsible party acknowledging receipt. Measures put in place to ensure that deficient practice does not recur: • All current nurses (including agency nurses that are scheduled to work) provided education on what needs to be completed for each discharge, including medication list and completed discharge instructions, along with obtaining signatures to ensure receipt by resident/family at time of discharge. Education to be completed by March 17th for all currently employed staff, and at time of floor orientation for new employees hired after 3-17-23. Agency nurses working for the first time at the facility after 3-17-23 will have a written acknowledgement they must review and sign regarding discharge requirements prior to starting their shift. How the facility plans to monitor its performance to ensure solutions are	

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F 660	Continued From page 4 was no medication list provided and they did not know what medications had been given to the resident medications on the day of discharge. -the family member/caregiver stated they were checking her oxygen saturation level and it was stable at rest with readings of 92- 93%. She would get out of breath with activity such as taking a shower, her oxygen level would decrease below 90 and would come back after she rested. She noted she had called the primary care provider and was told to call 911 if the oxygen level did not come back up after activity. A phone interview was done on 02/20/23 at 3:52 PM with Nurse #1 who was assigned to Resident #1 on 01/17/23. She said it was her first day working at the facility, and she had no recall of the resident or her discharge. An interview was done with Unit Manager (UM) #1 on 02/20/23 at 5:04 PM. He was asked about the discharge process, and stated at discharge the nurse completed the discharge and if any questions he assisted. He said the nurse usually printed the transfer/discharge report. He noted for the nurse discharging a resident, especially when it was an agency nurse, and their first day they tried to guide them. He recalled talking to Nurse #1 about how to complete the discharge for Resident #1. He said the nursing part of the discharge form should have been filled out. The Unit Manager said the prescriptions were printed out from the computer prior to discharge and signed by the NP. He noted the expectation was the discharging nurse would go over the discharge instructions, and the resident or RP would sign and date the transfer/discharge form.	F 660	sustained: • Five discharges per week (or less if discharged number is less than 5) will be reviewed for completion of the discharge instructions and signatures by resident/responsible party to ensure receipt for one month. • Five discharges per month for 2 additional months will be reviewed. • Review of findings will be presented during QAPI meeting at the end of monitoring period and changes made if further issues identified. Date of compliance is March 17th, 2023 The Administrator is responsible for implementing the acceptable plan of correction.	

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The UM said Nurse #1 should have given the family member the prescriptions, a copy of the medication list, and the transfer/discharge instructions.

A phone interview was done on 02/20/23 at 4:14 PM with Unit Manager #2 regarding the discharge process. She noted each of the disciplines should have completed their section of the Discharge Instructions/Post Discharge Plan of Care form. She said normally nursing would complete their section, they print two copies, the resident or RP sign and date one copy for the medical record and a copy was given to the resident/RP.

An interview was done on 02/20/23 at 6:26 PM with the Administrator and the Director of Nursing (DON). The DON said the discharge packet was done prior to the day of discharge and the prescriptions were printed out. The DON stated the discharge nurse should have given the resident/RP the printed prescriptions, and the discharge summary should have been attached to the prescriptions.

A follow-up phone interview was done with the DON on 02/21/23 at 2:00 PM regarding the discharge process. She stated Resident #1 and family should have received the prescriptions and the discharge summary. The DON said that included the form for discharge with the nursing instructions, the medication list, rehabilitation instructions and the social worker documentation with the home health referrals.

The Administrator was interviewed via phone on 02/21/23 at 2:05 PM about the discharge process. She said when a resident was discharged her expectation was that the facility

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F 660	Continued From page 6 had set up all services and provided the information to the family. This was to include the medication list, prescriptions and any other additional services..	F 660		