STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING ______ B. WING ______	C 04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	**13825 HUNTON LANE HUNTERSVILLE, NC 28078**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview and family interview, the facility failed to allow 1 of 3 sampled residents to return to the facility from an emergency department visit. (Resident #4).	F 201	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS	5/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 05/04/2015

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

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F 201	Continued From page 1 The findings included: Resident #4 was admitted to the facility on 03/21/15 with diagnoses including conversion disorder, epilepsy, depression, neurogenic bladder, muscle weakness and a new status post colostomy. She was admitted for short term rehabilitation. The Minimum Data Set, a 5 day assessment dated 03/25/15, noted she was cognitively intact, scoring a 14 out of 15 on the brief interview for mental status. This MDS coded her with verbal behaviors and rejection of care and requiring extensive assistance with bed mobility, transfers, and using a wheelchair for locomotion. Nursing notes dated 03/25/14 for 3 PM to 11 PM noted Resident #4 transferred to a new room on the first shift. She was out of the facility until "hs" (hour of sleep). She required 2 staff to assist to transfer and complained of severe generalized pain for which she received medication with a positive effect. Nursing notes dated 03/26/15 at 4:30 AM revealed her nurse aide reported at 3:30 AM Resident #4 was in her room very upset about missing a bag. The resident told the nurse "my things were stolen from me out of spite because when I returned staff wasn't even saying hello to me the same." Staff redirected her. Resident #4 denied being in pain and then stated she was bleeding from her vagina. The nurse noted "pink tinge residue on tissue" that she used to wipe herself when in the bathroom. The note went on to say the resident called the police. As staff assisted her to the front door she was yelling and screaming. She was picked up at 4:10 AM and	F 201	ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 4 was safely discharged home by the hospital Discharge Planner, who made a safe and coordinated discharge to the residents personal home with home health in place for continued services. Per chart audits and interview of staff (Administrator, DON, Medical Records) no other resident has ever been affected by the alleged deficient practice. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Administrator and DON have been reeducated in the proper understanding of the Regulations covering the Transfer, Discharge and Admission of Residents. Reeducation was conducted on 04-21-15 by the Vice President of the facility. Both voiced understanding and commitment to upholding the regulations for all transfers/discharges and admissions for residents as outlined in the regulations. An audit of all transfers/discharges since 03-21-15 has been completed by the Vice President and President of the facility to ensure that each transfer and/or discharge was completed in compliance	

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F 201 Continued From page 2

taken to a hospital per her request. The note indicated the physician's group was notified and the resident's family member was notified. The family stated they would call back with information.

There were no other nursing notes describing any further events in the medical record after Resident #4 left the facility with the emergency responders.

Social progress notes dated 03/27/15 noted Resident #4 was receiving therapy and preferred her family complete her paperwork. This note stated she planned to return home at the completion of therapy and when she was medically stable.

Social progress notes dated 03/28/15 noted Resident #4 was transported to (a named) hospital and family decided to discharge her back home.

On 04/13/15 at 1:26 PM the Director of Nursing (DON) stated that on 03/26/15 Resident #4 called 911 in the middle of the night screaming that the facility was not taking care of her and she wanted a medicine bag that the family had taken home earlier in the day. She also complained of bleeding profusely which could not be verified upon nursing assessment. Resident #4 was noted to scream and bang on all the residents' doors in the halls, disturbing other residents until the emergency responders picked her up and transported her to the hospital. She stated the resident did not return to the facility. DON further stated that when family arrived to obtain a wheelchair to bring Resident #4 back from the hospital, the DON told the family that she could

F 201

with the regulations. No other resident has been found to be affected by the alleged deficient practice.
All transfers/discharges will continue to be reviewed by either the VP or President for an additional 60 days with all records being reviewed. Then additional audits will be conducted for the next 60 days where at least 10% of the weekly discharges are reviewed, then the next 90 days and every quarter thereafter for a twelve month period of time ending 05-01-16 with 10% of the weekly discharges reviewed for adherence to the regulations.
Any deficient practice with facility transfers and/or discharges will be discussed with the facility administrator, DON and Medical Director. Reeducation if and where needed will be conducted with the administrator, DON and facility staff.
ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR:
The Administrator and DON have been reeducated in the proper understanding of the Regulations covering the Transfer, Discharge and Admission of Residents. Reeducation was conducted on 04-21-15 by the Vice President of the facility. Both voiced understanding and commitment to upholding the regulations for all transfers/discharges and admissions for residents as outlined in the regulations.
An audit of all transfers/discharges since 03-21-15 has been completed by the Vice President and President of the facility to ensure that each transfer and/or

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F 201	Continued From page 3 not return and that they needed to find someplace else for her to go. On 04/13/15 at 4:43 PM a phone interview was conducted with Resident #4 who stated she called 911 when she was bleeding and could not get staff to help her. She denied yelling and screaming. She stated the emergency responders took her to the hospital emergency department per her request. Resident #4 stated that when her family returned her to the facility and went in to obtain a wheelchair to assist her out of the car, DON told her family she could not return to the facility and had all her belonging packed up already. She stated she did not leave the nursing facility willingly when she returned from the emergency room. A telephone interview on 04/13/15 at 5:06 PM with the family member who tried to bring Resident #4 back to the facility on 03/26/15 from the emergency department revealed he was given no reason for discharge and the facility threatened to call the police if the family did not leave the premises. On 04/14/15 at 8:46 AM the social worker (SW) was interviewed. She stated that she was aware the resident had the diagnosis of conversion disorder and tried to make sure all the admission paperwork was reviewed and understood with both the resident and the family. She stated that on 03/26/15 she had a room change, went out with her family and when she returned she was very happy with the new room arrangements. Over the night the resident got upset and called the police to take her to the hospital. SW stated she was off the next day when the resident tried to return to the facility.	F 201	discharge was completed in compliance with the regulations. No other resident has been found to be affected by the alleged deficient practice. All transfers/discharges will continue to be reviewed by either the VP or President for an additional 60 days with all records being reviewed. Then additional audits will be conducted for the next 60 days where at least 10% of the weekly discharges are reviewed, then the next 90 days and every quarter thereafter for a twelve month period of time ending 05-01-16 with 10% of the weekly discharges reviewed for adherence to the regulations. Any deficient practice with facility transfers and/or discharges will be discussed with the facility administrator, DON and Medical Director. Reeducation if and where needed will be conducted with the administrator, DON and facility staff. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: All of the audits conducted by the VP or President will be submitted to the QA Committee and reviewed in QA for conformance with the regulations to ensure a safe, coordinated and planned	

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F 201	Continued From page 4 The DON was interviewed again on 04/14/15 at 11:22 AM. The DON stated that the third shift nurse was waiting for her when she arrived for work on 03/26/15 to inform her of the events during the early morning hours involving Resident 4 disrupting the facility and calling 911. DON stated that she did nothing regarding this incident when she first was told about it. Then around 10 AM and 11 AM, the family returned to the facility asking for a wheelchair to help her back in the facility. DON stated she did not see the resident and told the family that the facility could not meet Resident #4's needs because residents and families had complained that Resident #4 had been so disruptive during the night. DON stated that the resident didn't want to be at the facility based on the previous day when she expressed the desire to go home against medical advice, she wanted to be home and that was what the family and facility should work towards. She further stated the family was not polite and called DON names and finally DON threatened to call the police if family did not leave the premises. DON admitted that she had not spoken to the emergency department regarding what was done for Resident #4 and had not spoken with her physician. She stated that she informed the Administrator of the events but made the decision on her own not to take Resident #4 back into the facility. DON stated that after the incident with the family she received a call from the local hospital where Resident #4 showed up in the emergency department. DON explained her position for not wanting to readmit her and the circumstances that occurred during the night. The hospital stated they would see what they could do and the hospital made arrangements for Resident #4 to return home.	F 201	discharge for all residents. The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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F 201	Continued From page 5 Interview with the Administer occurred on 04/14/15 at 11:41 AM. Administrator stated the DON informed him of the events but he was out of the facility. He stated he knew that the facility had the responsibility to take Resident #4 back after the emergency room visit and he was the only one in authority to decide if a resident was not permitted to return to the facility. Administrator stated that his understanding was that the hospital had made home care arrangements for Resident #4 and she went home with services in place. Further interview with the DON on 04/14/15 at 12:35 PM revealed DON thought when Resident #4 called the police on her own to leave the facility, she was effectively signing herself against medical advice. The medical record did not have any documentation to support Resident #4 left against medical advice.	F 201		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents,	F 204		5/8/15

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F 204	Continued From page 6 as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, resident interview and hospital personnel interview, the facility failed to provide a safe and orderly discharge for 1 of 3 sampled residents. Resident #4 was turned away at the facility door when she returned with family from an emergency department visit. The finding included: Resident #4 was admitted to the facility on 03/21/15 with diagnoses including conversion disorder, epilepsy, depression, neurogenic bladder, muscle weakness and a new status post colostomy. She was admitted for short term rehabilitation. The Minimum Data Set, a 5 day assessment dated 03/25/15, noted she was cognitively intact, scoring a 14 out of 15 on the brief interview for mental status. This MDS coded her with verbal behaviors and rejection of care and requiring extensive assistance with bed mobility, transfers, and using a wheelchair for locomotion. Nursing notes dated 03/25/14 for 3 PM to 11 PM noted Resident #4 transferred to a new room on the first shift. She was out of the facility until "hs" (hour of sleep). She required 2 staff to assist to transfer and complained of severe generalized pain for which she received medication with a positive effect. Nursing notes dated 03/26/15 at 4:30 AM revealed her nurse aide reported at 3:30 AM	F 204	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 4 was safely discharged home by the hospital Discharge Planner, who made a safe and coordinated discharge to the residents□ personal home with home health in place for continued services. Per chart audits and interview of staff (Administrator, DON, Medical Records) no other resident has ever been affected by the alleged deficient practice. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: The Administrator and DON have been reeducated in the proper understanding of the Regulations covering the Transfer, Discharge and Admission of Residents. Reeducation was conducted on 04-21-15 by the Vice President of the facility. Both voiced understanding and commitment to upholding the regulations for all transfers/discharges and admissions for residents as outlined in the regulations. An audit of all transfers/discharges since 03-21-15 has been completed by the Vice President and President of the facility to ensure that each transfer and/or	

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F 204 Continued From page 7

Resident #4 was in her room very upset about missing a bag. The resident told the nurse "my things were stolen from me out of spite because when I returned staff wasn't even saying hello to me the same." Staff redirected her. Resident #4 denied being in pain and then stated she was bleeding from her vagina. The nurse noted "pink tinge residue on tissue" that she used to wipe herself when in the bathroom. The note went on to say the resident called the police. As staff assisted her to the front door she was yelling and screaming. She was picked up at 4:10 AM and taken to a hospital per her request. The note indicated the physician's group was notified and the resident's family member was notified. The family stated they would call back with information.

There were no other nursing notes describing any further events in the medical record after Resident #4 left the facility with the emergency responders.

Social progress notes dated 03/27/15 noted Resident #4 was receiving therapy and preferred her family complete her paperwork. this note stated she planned to return home at the completion of therapy and when she was medically stable.

Social progress notes dated 03/28/15 noted Resident #4 was transported to (a named) hospital and family decided to discharge her back home.

On 04/13/15 at 1:26 PM the Director of Nursing (DON) stated that on 03/26/15 Resident #4 called 911 in the middle of the night screaming that the facility was not taking care of her and she wanted

F 204

discharge was completed in compliance with the regulations. No other resident has been found to be affected by the alleged deficient practice.
All transfers/discharges will continue to be reviewed by either the VP or President for an additional 60 days with all records being reviewed. Then additional audits will be conducted for the next 60 days where at least 10% of the weekly discharges are reviewed, then the next 90 days and every quarter thereafter for a twelve month period of time ending 05-01-16 with 10% of the weekly discharges reviewed for adherence to the regulations.
Any deficient practice with facility transfers and/or discharges will be discussed with the facility administrator, DON and Medical Director. Reeducation if and where needed will be conducted with the administrator, DON and facility staff.
ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR:
The Administrator and DON have been reeducated in the proper understanding of the Regulations covering the Transfer, Discharge and Admission of Residents. Reeducation was conducted on 04-21-15 by the Vice President of the facility. Both voiced understanding and commitment to upholding the regulations for all transfers/discharges and admissions for residents as outlined in the regulations.
An audit of all transfers/discharges since 03-21-15 has been completed by the Vice President and President of the facility to

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F 204	Continued From page 8 a medicine bag that the family had taken home earlier in the day. She also complained of bleeding profusely which could not be verified upon nursing assessment. Resident #4 was noted to scream and bang on all the residents' doors in the halls, disturbing other residents until the emergency responders picked her up and transported her to the hospital. She stated the resident did not return to the facility. DON further stated that when family arrived to obtain a wheelchair to bring Resident #4 back from the hospital, the DON told the family that she could not return and that they needed to find someplace else for her to go. On 04/13/15 at 4:43 PM a phone interview was conducted with Resident #4 who stated she called 911 when she was bleeding and could not get staff to help her. She denied yelling and screaming. She stated the emergency responders took her to the hospital emergency department per her request. Resident #4 stated that when her family returned her to the facility and went in to obtain a wheelchair to assist her out of the car, DON told her family she could not return to the facility and had all her belonging packed up already. She stated she did not leave the nursing facility willingly when she returned from the emergency room. A telephone interview on 04/13/15 at 5:06 PM with the family member who tried to bring Resident #4 back to the facility on 03/26/15 from the emergency department revealed he was given no reason for discharge and the facility threatened to call the police if the family did not leave the premises. On 04/14/15 at 8:46 AM the social worker (SW)	F 204	ensure that each transfer and/or discharge was completed in compliance with the regulations. No other resident has been found to be affected by the alleged deficient practice. All transfers/discharges will continue to be reviewed by either the VP or President for an additional 60 days with all records being reviewed. Then additional audits will be conducted for the next 60 days where at least 10% of the weekly discharges are reviewed, then the next 90 days and every quarter thereafter for a twelve month period of time ending 05-01-16 with 10% of the weekly discharges reviewed for adherence to the regulations. Any deficient practice with facility transfers and/or discharges will be discussed with the facility administrator, DON and Medical Director. Reeducation if and where needed will be conducted with the administrator, DON and facility staff. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: All of the audits conducted by the VP or President will be submitted to the QA Committee and reviewed in QA for conformance with the regulations to	

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 9 was interviewed. She stated that she was aware the resident had the diagnosis of conversion disorder and tried to make sure all the admission paperwork was reviewed and understood with both the resident and the family. She stated that on 03/26/15 she had a room change, went out with her family and when she returned she was very happy with the new room arrangements. Over the night the resident got upset and called the police to take her to the hospital. SW stated she was off the next day when the resident tried to return to the facility. The DON was interviewed again on 04/14/15 at 11:22 AM. The DON stated that the third shift nurse was waiting for her when she arrived for work on 03/26/15 to inform her of the events during the early morning hours involving Resident #4 disrupting the facility and calling 911. DON stated that she did nothing regarding this incident when she first was told about it. Then around 10 AM and 11 AM, the family returned to the facility asking for a wheelchair to help her back in the facility. DON stated she did not see the resident and told the family that the facility could not meet Resident #4's needs because residents and families had complained that Resident #4 had been so disruptive during the night. DON stated that the resident didn't want to be at the facility based on the previous day when she expressed the desire to go home against medical advice, she wanted to be home and that was what the family and facility should work towards. She further stated the family was not polite and called DON names and finally DON threatened to call the police if family did not leave the premises. DON admitted that she had not spoken to the emergency department regarding what was done for Resident #4 and had not spoken with her	F 204	ensure a safe, coordinated and planned discharge for all residents. The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING ______ B. WING ______	C 04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 204	Continued From page 10 physician. She stated that she informed the Administrator of the events but made the decision on her own not to take Resident #4 back into the facility. DON stated that after the incident with the family she received a call from the local hospital where Resident #4 showed up in the emergency department. DON explained her position for not wanting to readmit her and the circumstances that occurred during the night. The hospital stated they would see what they could do and the hospital made arrangements for Resident #4 to return home. On 04/16/15 at 1:55 PM a telephone interview was conducted with hospital staff #1 from a local hospital emergency department (Hospital #1). Hospital staff #1stated Resident #4 was seen at their emergency room on 03/26/15 after having been refused readmission to the nursing facility due to disruptive behaviors after the resident called 911 herself. Family subsequently took her to this hospital. A telephone interview was conducted on 04/15/15 at 2:15 PM with hospital staff #2 from a different local hospital (Hospital #2). Hospital staff #2 confirmed that Resident #4 came to the emergency department from the nursing facility after the resident herself called 911 on 03/26/15. Hospital staff #2 stated Resident #4 left the hospital emergency department around 10 AM with her family with plans to return to the nursing facility. She stated the hospital notes revealed no problems with the discharge back to the nursing facility and she assumed Resident #4 returned to the nursing facility. Hospital staff #3 from Hospital #1 was interviewed on 04/16/15 at 1:32 PM via telephone. Per hospital staff #3, Resident #4 left the nursing facility after calling 911 on 03/26/15,	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 204	Continued From page 11 was transported by the emergency responders to Hospital #2 emergency department. From there Resident #4 returned to the nursing facility with family transportation. The nursing facility refused to take her back. Family reported to hospital staff #3 that family took the resident to another local skilled nursing facility and tried to get her admitted but that nursing facility instructed the family to return to a hospital. The family subsequently then showed up at Hospital #1's emergency department. At that time, hospital staff #3 called the facility and was told of the previous events involving the resident calling 911 herself and the facility not wanting to readmit her when family brought her back. Hospital staff #3 stated that she subsequently made arrangements for Resident #4 to return home with home care services since she was not appropriate for admission to the hospital, could transfer herself and had plans to return home after short term rehab at the facility.	F 204		