STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 05/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews family and staff interviews, the facility failed to provide the bed hold policy to a resident and the responsible party when the resident was discharged to the hospital for 1 of 3 sampled residents. The bed hold policy did not address the intent of the regulation (Resident #1). The findings included: Review of the admission packet dated 7/2011, read in part: Bed reservations: If the resident is transferred to a hospital in an emergency or pursuant to a physician ' s order, the facility would arrange for the transfer to the hospital. The facility	F 205	F-205 Deficiency corrected Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth of the Statement of Deficiencies. This plan of Correction is prepared and / or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 _____ 1. Resident #1 was admitted to a long-term acute care facility (LTAC).	5/29/15

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

Electronically Signed | 06/03/2015

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F 205	Continued From page 1 would also notify the legal representative, a family member or surrogate of the transfer. If the resident is admitted to the hospital, the facility would hold the bed for a private pay resident for up to thirty days as long as payment for the bed hold is made at the per diem rate consistent with the resident ' s payer status. Where Medicaid pays for bed holds, Medicaid may pay to hold the bed for the Medicaid eligible resident for up to fifteen days for any single hospital stay if it is determined by the resident ' s medical condition that the resident would be returning to the nursing home. At any time during this fifteen day period, Medicaid may determine it would no longer pay to hold the bed. Once Medicaid determines it will no longer pay to hold the bed, or at the completion of the 15 day period, the resident may choose to hold the bed as described above for private pay residents. The bed hold policy did not give the Medicaid resident the right to return back to the first available bed. Resident #1 was admitted to the facility on 1/30/03. The diagnoses included recurrent cellulitis, diabetes, chronic pain, hypertension, anxiety and depression. The Minimum Data Set (MDS) dated 2/5/15, revealed that Resident #1 had some cognition and decision making problems. Resident #1 required extensive to total assistance with activities of daily. Review of revised care plan dated 3/18/15, identified the problem as: Indwelling catheter related to buttock and sacral wounds. The goal included resident would have no complications from the catheter. The approach included monitor for signs and symptoms of infection, monitor catheter and change per physician ' s order. Review of record dated 1/9/15 and 4/3/15 revealed that Resident #1 was transferred to the hospital for recurrent cellulitis of bilateral lower	F 205	2. All residents have the potential to be affected by this alleged practice. The director of nursing inserviced licensed staff regarding the facility's bed-hold policy for residents being transferred to the hospital. All licensed staff were inserviced as of May 29, 2015. All new licensed employees will be inserviced at their nursing orientation. 3. Upon admission, each resident/responsible party shall be given a copy of the facility's bed-hold policy and the same policy explained to the resident/responsible party by a staff member upon admission to the facility. When a resident is discharged and admitted to the hospital, a staff member will call the resident/responsible party and explain the bed -hold policy and an option given to place a bed-hold. 4. The Administrator and or designee will review resident discharges to the hospital, the next business day, for the next three months and randomly thereafter, to validate that the resident/responsible party was notified of the facility bed-hold policy and option to place a bed-hold. The Administrator and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for a three month period and randomly thereafter to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. Compliance was achieved on 5-29-2015.	

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extremities and wounds to the buttocks. Review of the nurse ' s notes during the transfers did not indicated a discussion of the bed hold policy or procedures was held with resident or family representative.
Review of physician ' s order dated 3/15/15 through 4/1/15, revealed on-going treatment for cellulitis of lower extremities, insertion of a catheter for sacral wounds/buttocks and pain management.
Review of the hospital discharge summary dated 4/21/15, revealed a progress note dated 4/20/15, indicated Resident #1 cellulitis of lower extremities was resolved and the identified pressure ulcers to the buttocks, thigh and sacrum were unstageable. The facility was contacted for readmission for Resident #1 and denied readmission due to facility inability to meet Resident #1 care needs per FL2 form dated 4/21/15.
During an interview on 5/11/15 at 11:45AM, the family member indicated that Resident #1 had been at the facility several years as a Medicaid resident and had not experienced any concerns with readmission prior to the last hospitalization. The family member indicated the she was unaware of a bed hold policy until it was brought to her attention by the hospital social worker when Resident#1 was denied readmission. The hospital social worker inquired about bed availability and was told by facility staff that Resident #1 could not be readmitted due to the facility ' s inability to provide the care that was needed for Resident #1 and the condition of the current wounds. The family member indicated that Resident#1 developed the pressure ulcers prior to hospital admission and felt that since the hospital had treated the ulcers and prepared Resident #1 for discharge there should have

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been no reason for Resident #1 not to be readmitted to her previous home. The facility was not at full capacity and other beds were available, there was no reason why Resident #1 was admitted to another skilled facility to receive the same type of care as provided by her previous residence. The family added that she was unaware of any bed hold information sent with Resident #1 to the hospital.

During an interview on 5/11/15 at 12:28PM, the wound care nurse indicated she was unaware of what the bed hold policy/procedure process entailed. She indicated that she had not reviewed any of this information with the resident or family on any of the discharges. It was to her knowledge that admissions or social work handled that discussion.

During an interview on 5/11/15 at 12:37PM, the Administrator indicated that Resident#1 had developed some wounds that were unmanageable by the facility and she was sent to the hospital for further treatment. He indicated that the bed hold policy had been offered to the resident/family prior to discharge and she had exceeded the 15 day discharge period per the policy. He added that there was a bed available at the time Resident #1 was scheduled for discharge from the hospital, however the medical director gave instructions not readmit Resident #1 because they were unable to meet her needs. He was unable to specifically state what need could not be met. He further stated that since the wound size increased and new wounds development that was the primary reason for not accepting her back to the facility. He indicated that nursing was responsible for the discussion of the bed hold policy/procedures and what should

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F 205	Continued From page 4 be sent with the residents to the hospital. During an interview n 5/11/15 at 1:08PM, the director of nursing (DON) indicated that she was unaware of the Medicaid/Medicare regulation for readmission once the resident exceeded the 15 day threshold for hospitalization. In addition, there was beds available at the time of Resident #1 ' s scheduled discharge, but the determination was based on physician instruction not to readmit due to facility ' s inability to meet Resident#1 wound care needs. She indicated that prior to 3/15/15, there was no bed hold policy available by the previous company, the staff would not have discussed the expectations of the bed hold process. During an interview on 5/11/15 at 2:15PM, the admission coordinator, indicated that prior to new management effective March 2015 there was no discussion of the bed hold policy/procedures done with residents or family. She confirmed she did not offer or discuss the bed hold process when the resident was discharged in April 2025 or prior to March 2015. She indicated the new SNF contacted her today (5/11/15) inquiring about Resident #1 ' s Medicaid days. She further stated that she was unaware she should have taken Resident #1 back since also had exceeded her 15 day period bed hold. She added that she was unaware of the Medicaid/Medicare regulation for readmission of Medicaid/Medicare residents to the 1st available until she contacted a sister facility. During an interview on 5/11/15 at 2:30PM, the physician indicated he was not aware of the bed hold policy and procedures for Medicaid/Medicare residents, nursing and admissions handled those	F 205		

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F 205	Continued From page 5 discussions. During an interview on 5/12/15 at 12:12PM, the social worker director indicated she did not speak with Resident #1 ' s family regarding bed hold policy. She indicated that she found out after the fact that resident was denied readmission in a standup meeting. In addition, she was uncertain whether it was the DON or admission that reported Resident #1 would not be returning. She further stated she was not involved in any discussion regarding bed hold during discharge and unaware of the policy/process. During an interview on 5/12/15 at 2:45PM, Nurse #2 indicated that he was unaware of the bed hold policy/procedures or any paperwork required to be sent with resident when discharged to the hospital. He indicated that he was unaware of who was responsible for discussion bed hold process. During an interview on 5/12/15 at 3:00PM, Nurse #3 indicated that she had not discussed the bed hold policy/procedures with the resident or family. She also indicated she was unaware of any concerns with Resident #1 being readmitted to the facility since she had been discharged and readmitted several times for the same condition with no problems.	F 205		
F 206 SS=B	483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if	F 206		5/29/15

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F 206	Continued From page 6 the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to readmit Resident #1 to the first available bed after being discharged from the hospital for 1 of 3 Medicaid sampled residents(Resident #1). The findings included: Review of the admission packet dated 7/2011, read in part: Bed reservations: If the resident is transferred to a hospital in an emergency or pursuant to a physician ' s order, the facility would arrange for the transfer to the hospital. The facility would also notify the legal representative, a family member or surrogate of the transfer. If the resident is admitted to the hospital, the facility would hold the bed for a private pay resident for up to thirty days as long as payment for the bed hold is made at the per diem rate consistent with the resident ' s payer status. Where Medicaid pays for bed holds, Medicaid may pay to hold the bed for the Medicaid eligible resident for up to fifteen days for any single hospital stay if it is determined by the resident ' s medical condition that the resident would be returning to the nursing home. At any time during this fifteen day period, Medicaid may determine it would no longer pay to hold the bed. Once Medicaid determines it will no longer pay to hold the bed, or at the completion of the 15 day period, the resident may choose to hold the bed as described above for private pay residents. The bed hold policy did not give the Medicaid resident the right to return back to the	F 206	F-206 Deficiency corrected Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth of the Statement of Deficiencies. This plan of Correction is prepared and / or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 _____ 1. Resident #1 was admitted to another skilled nursing facility. 2. No other residents were affected by this alleged deficient practice. 3. The Admissions coordinator, Director of Nursing and Medical Director were educated regarding admission criteria on 5-29-2015. Readmissions and referrals will be reviewed by the admissions¿ coordinator and/or the DON, and/or the medical director prior to bed offers so as to assure that the facility can meet the potential residents needs that have been outlined in the documentation of the discharging hospital¿s referral. 4. The Admissions coordinator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for three months and randomly thereafter to	

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F 206	Continued From page 7 first available bed. Resident #1 was admitted to the facility on 1/30/03. The diagnoses included recurrent cellulitis, diabetes, chronic pain, hypertension, anxiety and depression. The Minimum Data Set (MDS) dated 2/5/15, revealed that Resident #1 had some cognition and decision making problems. Resident #1 required extensive to total assistance with activities of daily. Review of revised care plan dated 3/18/15, identified the problem as: Indwelling catheter related to buttock and sacral wounds. The goal included resident would have no complications from the catheter. The approach included monitor for signs and symptoms of infection, monitor catheter and change per physician ' s order. During an interview on 5/11/15 at 12:28PM, the wound care nurse indicated that Resident #1 wounds were being treated to the best of the facility ability with several changes made by the physician. She indicated that several options in treatment and preventive devices were tried and Resident #1 was non-compliant with keeping things like wedges/ pillows in place. She would constantly ask staff to remove the devices. The physician had been following and monitoring the wound and the size and condition continued to increase, therefore, the physician ordered a transfer to a specialty hospital in an effort to decrease the size and improve the condition. She added due to Resident#1 physical condition nodules started to develop that was not controllable in size and condition. She was unaware of any concerns of why Resident #1 could not return to the facility for care once the wounds had improved while in the hospital. She added that to her knowledge the wounds increased in sized while in the hospital. She indicated that she did not see a reason why the	F 206	evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. Compliance was achieved on 5-29-2015.	

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wounds could not be continued to be cared for in the facility since the physician was a wound specialist.

During an interview on 5/11/15 at 12:37PM, the Administrator indicated that Resident#1 had developed some wounds that were unmanageable by the facility and she was sent to the hospital for further treatment. He indicated that the bed hold policy had been offered to the resident/family prior to discharge and she had exceeded the 15 day discharge period per the policy. He added that there was a bed available at the time Resident #1 was scheduled for discharge from the hospital, however the medical director gave instructions not readmit Resident #1 because they were unable to meet her needs. He was unable to specifically state what need could not be met. He further stated that since the wound size increased and new wounds development that was the primary reason for not accepting her back to the facility. He indicated that nursing was responsible for the discussion of the bed hold policy/procedures and what should be sent with the residents to the hospital.

During an interview n 5/11/15 at 1:08PM, the director of nursing (DON) indicated Resident #1 was admitted to the hospital wound management. She acquired 2 additional wounds while in the hospital and the physician did not feel that the facility could meet the wound care needs because the increase and size of the wounds. The wounds were in the formation in cauliflower like presentation that had drainage. The measurement of the wounds when sent from the facility had increased in size when the resident discharge summary was sent back. She indicated that she had spoken with the nurse consultant

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and physician and felt like the wounds could not be managed in the facility. The resident needed specialty care and treatment for the wounds that could not be done in the facility. In addition, there was beds available at the time of Resident #1 ' s scheduled discharge, but the determination was based on physician instruction not to readmit due to facility ' s inability to meet Resident#1 wound care needs.

During an interview on 5/11/15 at 2:15PM, the admission coordinator, indicated that Resident #1 was not offered her bed back when she was schedule for return because she was given the instruction by corporation office and director of nursing not to readmit because the facility could no longer meet Resident #1 ' s needs because the wounds had were larger in size and had worsen. The admissions coordinator indicated a bed was available at the time the hospital discharge staff contacted her. She indicated the new SNF contacted her today inquiring about Resident #1 ' s Medicaid days. She further stated that she was unaware she should have taken Resident #1 back since also had exceeded her 15 day period bed hold. She added that she was unaware of the Medicaid/Medicare regulation for readmission of Medicaid/Medicare residents to the 1st available until she contacted a sister facility.

During an interview on 5/11/15 at 2:30PM, the physician indicated the primary reason for sending Resident #1 to the specialty hospital was for aggressive treatment of several wounds that had increased in size and wound management. The physician stated that he felt if the LTAC (long term acute care) could not heal the wounds that had grown in size as well as the development of

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new wounds the facility could not meet Resident #1 ' s needs. He further stated the referral to the hospital was for the aggressive treatment and felt that the first step for the hospital would have been to Resident #1 for plastic surgery evaluation since the wounds increased and new ones developed while at the hospital. He indicated his decision was made after verbal report of the new wound development and review of the discharge summary which indicated the size changes of the wounds not to accept Resident #1 back to the facility. In his opinion the wounds had gotten worse and she developed new ones that the facility could not meet her wound care needs. He further stated that if the wounds had gotten better she could have returned to the facility. When asked what part of Resident #1 ' s needs could not be met, the response was due to the increase size of the wound and new development of wounds, the facility could not treat the wounds properly. The physician confirmed his decision for denial of readmission was the facility could not meet her wound care needs. He indicated that he was unaware of the facility census at the time and that Resident #1 was transferred to another skilled facility.

During an interview on 5/12/15 at 2:45PM, Nurse #2 indicated he was unaware of any concerns of why Resident #1 could not be readmitted to the facility since she had several admissions and discharges with no concerns.

During an interview on 5/12/15 at 3:00PM, Nurse #3 indicated that Resident #1 had several wound concerns prior to discharge and would resist care at times in which she required several staff to assist with care. She added that majority of the treatment included topical treatments for cellulitis

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F 206	Continued From page 11 or dermatitis. She developed some pressure ulcers the middle part of March through April which was being treated by physician and wound care nurse. The wounds continued to increase in size and the condition changed, therefore the physician decided to send Resident #1 to the hospital for additional treatment and stabilization. She also indicated she was unaware of any concerns with Resident #1 being readmitted to the facility since she had been discharged and readmitted several times for the same condition with no problems.	F 206		