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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/3/18 until 12/6/18 to investigate Intake # NC00144001. The survey team substantiated the allegation of safe and orderly discharge in this intake at tag F660 at a scope and severity of a D. Per the Quality Improvement Committee and CMS reviews and recommendations, the survey team returned to the facility on 2/6/19 to collect additional information regarding the issue of safe and orderly discharge. The survey team exited the facility on 2/8/19. The survey team identified immediate jeopardy at Past-noncompliance in the following regulatory groupings: CFR 483.15 at tag F624 at a scope and severity (J) CFR 483.21 at tag F660 at a scope and severity (J) Immediate Jeopardy began on 10/4/18 and was removed on 1/4/19.	F 000		
F 624 SS=J	A Partial extended survey was conducted. 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	F 624		2/22/19

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

Electronically Signed | 03/04/2019

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F 624	Continued From page 1 by: Based on record reviews, interviews with the facility staff, home health agency staff, van driver and family member the facility failed to provide a safe discharge planning process that included discharge goals, needs and caregiver support for 1 of 4 residents reviewed for discharge (Resident #1). The facility failed to ensure a safe place to go to after being discharged from the facility. The facility failed to assess Resident #1's medical condition to identify possible barriers for a safe discharge home. The findings included: Resident #1 was admitted to the facility on 8/28/18 after a recent hospital course for a left hip hemiarthroplasty (replacement of half of the hip joint) due to a fall at home that resulted in a left femoral fracture. The resident's cumulative diagnoses included diabetes, heart failure, hypertension, atrial fibrillation and cerebral infarction. Review of a 48-hour interim care plan for Resident #1 dated 8/28/18 revealed a goal that resident would have a smooth transition to home/assisted living facility. Approaches included to initiate discharge planning, provided resident/representative with information regarding community resources and educate resident/representative on services provided in the facility. Review of the 14-day Minimum Data Set (MDS) dated 9/11/18 coded Resident #1 with severely impaired cognition. The MDS indicated Resident #1 required extensive assistance of 2 people for bed mobility, total assistance of 2 people for transfer, and required extensive assistance of one person for dressing, eating, toilet use, personal hygiene and bathing. The MDS indicated Resident #1 was incontinent of bowel	F 624	Past noncompliance: no plan of correction required.	

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and bladder. The resident's balance was coded as steady only when stabilized with staff assistance and her mobility device was a wheelchair. Resident #1 was also coded as expected discharge to the community.
A review of the comprehensive care plan dated 9/12/18 did not include a care plan for discharge planning.
A review of the treatment progress note dated 9/17/18 revealed Resident #1 had a newly acquired in-house identified unstageable pressure sore to the left buttock. An unstageable pressure sore has full thickness tissue loss in which the base of sore is covered by slough and/or eschar in the wound bed. Review of the wound assessment report dated 9/17/18 and 9/24/18 revealed this an in-house pressure sore to the left buttock measured 1.2 centimeters (cm) in length by 1.5 cm in width, no measurable depth with 100% slough tissue. There was no further assessment of the pressure sore or the draining incision site prior to discharge.
Review of the October 2018 physician orders included:
" Amlodipine 5 milligrams (mg) by mouth (po) every day (qd) for hypertension.
" Armour Thyroid 60 mg po qd for hypothyroidism.
" Aspirin 81 mg po qd for atrial fibrillation.
" Beneprotein 1 scoop three times a day as a protein supplement for wound healing.
" Bydureon 0.65 milliliter (2 mg) subcutaneous once a day on Mondays for diabetes.
" Carvedilol 25 mg twice a day for hypertension.
" Citalopram 40 mg po qd for depression.
" Dexamethasone 1 mg po qd a steroid to treat pituitary adenoma
" Eliquis 5 mg po twice a day. An

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anticoagulant.
" Humalog U-100 insulin per a sliding scale three times a day before meals for diabetic control.
" Lantus U-100 insulin per sliding scale at 8 pm for diabetic control.
" Lipitor 40 mg po qd for high cholesterol
" Metformin 1,000 mg po twice a day for high cholesterol.
" Potassium Chloride extended release 10 milliequivalent once a day for potassium replacement.
" Vitamin C 500 mg po twice a day for wound healing.
" MVI with minerals 1 qd po for wound healing.
" Vitamin D3 5,000-units qd po as a supplement.
" Zinc sulfate 220 mg po qd for wound healing.
" Donepezil 10 mg po at bedtime for memory enhancement.
" Cleanse sacral wound (pressure sore) with saline apply nickel thick sized Santyl ointment (enzymatic debriding ointment) and cover with calcium alginate (absorbent wound dressing) with a dry dressing daily.
A review of discharge paper work dated 9/28/18 for Resident #1 revealed no documentation related to treatment of the resident's pressure sore, draining incision site, information about the prescribed medications or monitoring of her finger sticks for blood glucose checks.
Record review revealed Resident #1 was discharged home on 10/4/18 via a transportation van service without facility staff.
An interview on 2/6/19 at 11:56 AM with the Treatment Nurse (TN) stated she did not educate the family about how to care for the pressure sore or the surgical incision site. Further interview revealed the home health agency would perform

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the dressing changes.
Interview on 2/6/19 at 1:21 PM with the Discharge Planner (DP) who stated the Medicare non-coverage for Resident #1 was in effect on 9/28/18. She stated the Responsible Party (RP) informed her they could not afford private pay so the Resident was to be discharged to her home on 9/28/18. Further interview revealed the family had at home a handicap van, hospital bed and wheelchair. The DP stated no one called and no one came to pick Resident #1 up on 9/28/18. The DP stated on 10/1/18 she received a phone call from Resident #1's RP who requested transportation to Resident's home and she referred them to a private van service. She stated she called the van service and made the transportation appointment for Resident #1. The DP stated she was unaware of the teaching/preparation of the discharge. She stated Home Health Agency #1 was the agency that approved Resident #1 admission for home care.
An interview on 2/6/19 at 2:20 PM with Nurse #10 indicated she administered the resident's medications crushed and mixed with pudding and required total care and was fragile. "I gave no instructions because the resident went home with home health services." Additionally, Nurse #10 stated she discharged the resident to no one and was told to complete the paper work. Nurse #10 stated she never saw a medication list or prescriptions to send home with the resident. She added home health was scheduled to be in the home the next day. Nurse #10 indicated 10/4/18 was the only day she had worked with this resident and she really didn't know much about her. She stated normally when she discharged a resident there was a family member present and she would review all of the medications and appointments with them. Nurse #10 added she

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didn't see any treatment orders for Resident #1's pressure sore. She stated this was not the normal process for discharging a resident.
An interview via the phone on 2/6/19 at 7:14 PM with Resident #1's RP revealed DP requested that they pick up the resident on 9/28/18. Resident #1's RP indicated that during that call she had informed the facility that they had no means to take care of Resident #1. She stated on 10/4/18 the facility called again and the next thing we knew Resident #1 was dropped off at home by a van. Resident #1's RP indicated they had no medications except insulin for the resident and they had no knowledge that the resident had a pressure sore on her buttocks. Resident #1's RP stated the facility just dumped Resident #1 off without any instructions on how to take care of her. She added the resident was placed in another nursing home. Continued interview revealed "I received only one sheet of paper. The RP continued to indicate the family did not have all the medications to administer and had told the facility that we could not take care of her at home due to inability to lift and move Resident #1. The home care nurse called the pharmacy to get the medications. The RP indicated she "Tried talking to DP who was rude and told us we had no choice but to bring her home."
An interview on 2/6/19 at 2:30 pm with Nursing Assistant (NA) #11 stated resident required total care for all activities of daily living, fed herself finger foods but staff needed to feed her. Resident was incontinent of urine and stool and would require 2 people to transfer her to the toilet. She needed staff to turn her at least every 2-3 hours and position her with pillows on her right side due to leaning.
An interview on 2/6/19 at 3:30 pm with Home Health Nurse #1 and Home Health Nurse #2

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(HHA) #1 and HHA Nurse #2 (nurse who conducted the initial evaluation on 10/5/18) was conducted via the phone. HHA Nurse #2 stated on arrival on 10/5/18 at 1:06 pm to Resident #1's home. Resident #1's brief, clothing and bed sheets were soaked with urine and incontinent episode of bowels. HHA Nurse #2 stated Resident #1 expressed to her that she was hungry and had not eaten all day. A family member then brought Resident#1 a pop tart and walked into and out of the room. There was no set up date for a follow-up with the physician nor were there any medications. HHA Nurse #2 stated she called the pharmacy for medication to be delivered and set up an appointment to the MD office. Additionally, there was no glucometer or strips to test the resident's blood glucose level. HHA Nurse #2 indicated by 10/24/18 the resident was transferred to another skilled facility.

An interview on 2/7/19 at 12:23 PM with the Transportation (TC) van driver indicated a family member was present when he arrived at the home. The van driver stated he brought Resident #1's personal belongings and a "discharge packet" to Resident #1's home. TC van driver stated no facility staff accompanied the resident where and a family member transferred the resident to bed so that he could return the facility's wheelchair.

Interview on 2/8/19 at 9 am with the Physical Therapist(Pt) revealed on the initial screening resident was maximal assist for bed mobility and did not have good body awareness due to previous stroke and limited motor skills. An inquiry was made about home visits and the PT therapist indicated that the rehab department does not conduct home visits and rely on the home health physical therapist to assess. The PT indicated the resident did not achieve her goals

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and needed maximal to moderate assistance from staff.
Interview on 2/6/19 at 12:40 pm with the Administrator revealed no facility staff accompanied resident home and was his expectation that staff follow the regulations (was not specific) for discharging residents home.
The facility implemented the following corrective action:
"Resident # 1 was admitted to Oak Forest Health and Rehabilitation on August 28, 2018 with diagnoses of hypertensive heart disease, Type 2 Diabetes Mellitus with Hyperglycemia, Presence of Left Artificial Hip Joint and Cerebral Infarction. Upon admission to facility, resident #1 was identified with Impaired Skin Integrity. A 48-hour interim care plan was completed on August 28, 2018 including discharge planning with goal of a smooth transition to home. Resident #1 received physician order for Occupational and Speech Therapy evaluations and treatments on August 28, 2018, and Physical Therapy evaluation and treatment on August 29, 2018. Resident received therapy services throughout her stay and required much encouragement to participate. On September 17, 2018 the facility Treatment Nurse discovered a pressure ulcer to Resident #1's left buttock. The Treatment Nurse completed the appropriate documentation for the pressure ulcer and notified resident's attending physician and Medical Director. New orders were received from the physician on September 18, 2018 for the treatment of the pressure ulcer. The treatment nurse did not notify the Resident Representative of the pressure ulcer. The discharge planning of Resident #1 included a referral for Home Health services to include PT, OT evaluation and treatment and nursing for treatment of sacral wound. The facility failed to do a home visit and

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evaluate any barriers in the home prior to discharge.
PT and OT services were discontinued on September 25, 2018 and ST services were discontinued on September 27, 2018. At this time resident had reached her maximum potential and an order on September 25, 2018 was received from the Medical Director to discharge resident home with family on September 28, 2018. On September 21, 2018 the discharge planner issued a Notice of Non-Coverage and discussed with Resident's Representative via phone call at 1:59 pm. Resident's Representative was notified of last covered day of skilled services to be on September 27, 2018. Resident's Representative verbalized understanding and confirmed the plan for resident to return home on September 28, 2018. Resident's Representative did not arrive to facility on September 28, 2018 to pick up Resident#1 as planned. At approximately 7pm, the charge nurse on duty notified the facility Administrator that the family had not picked resident up. The administrator instructed that facility would hold off on discharge and revisit issue on Monday, October 1, 2018. On October 1, 2018, the facility Social Worker attempted to contact Resident Representative and was unable to reach him. Social Worker then contacted second family member and left messages to return call. The second family member called Social Worker back on October 4, 2018 and requested for facility to transport Resident #1 home. Apollo Transportation was notified and agreed to transport resident and bill family for cost of transport. Resident was picked up at facility on October 4, 2018 and taken home and received by Resident Representative. Resident's discharge instructions including information regarding Yadkin Home Health agency was given

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to Resident Representative at time of transport. The facility failed to provide and document sufficient preparation and orientation to resident representative to ensure safe and orderly discharge from the facility. The family representative did not have knowledge of the resident's wound and treatment for the wound or that the left hip surgical incision site had small amount of drainage. The nurse failed to provide and review a medication list and medication prescriptions with family representative. Family training and documentation was not completed.
On October 4, 2018, the facility failed to train a family representative of Resident #1's medical condition including; wound care treatment/surgical incision drainage, medication listing review, and medication prescriptions, type of diet resident needed, level of supervision and ADL assistance needed prior to Resident #1's discharge home. The discharge planning of Resident #1 did include a referral for Home Health services to include PT, OT evaluation and treatment and nursing for treatment of sacral wound.
Corrective action accomplished for those residents found to have been affected by the deficient practice.
Resident #1 was discharged from the facility on October 4, 2018. At the time of this compliance, Resident #1 is residing in another skilled nursing facility.
Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
Starting December 13, 2018, the facility completed a 100% audit of all residents discharged within the last two weeks prior to the start of the original plan of correction regarding

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Resident #1. This audit included sixteen residents and no negative findings were found. This audit was completed on 12/14/18 and was to ensure the facility implemented an effective orientation, preparation, and transition to post-discharge care including education of medications and residents' medical treatment needs.
By failing to provide a family representative with a review of Resident #1's wound treatment, medication listing, and medication prescriptions, this is considered neglect according to regulation.
The discharge planner and nurse involved with Resident #1's discharge was educated on December 6, 2018 by the Administrator and Director of Nursing. The in-servicing included, but was not limited to; notification of changes, development, preparation, and implementation of a comprehensive care plan for discharge, as well as a preparation and implementation of the discharge planning process. The Director of Nursing, Assistant Director of Nursing, assistant administrator gave an in-service to all staff, including but not limited to the discharge planner, social worker and nurses starting January 2, 2019 and completed by January 4, 2019. The in-service included Abuse and Neglect education.
A 100% audit was completed utilizing a comprehensive care plan tool starting on 12/19/18 and completed on 12/20/18 of all current residents residing in the facility to ensure each resident had a discharge care plan. This audit was completed by Discharge Planner and Director of Nursing. Discharge Planner and Director of Nursing ensured the current care plan matched the discharge plan for each resident.
Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Upon admission, the discharge plan process is

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initiated. The interim care plan is initiated on admission by the admitting nurse and completed by the RN Unit Manager, Assistant Director of Nursing, and Director of Nursing. All nurses were educated by the Director of Nursing on December 17, 2018 about the requirement of the facility to develop and implement a care plan for each resident including the discharge plan. The interim care plan includes the discharge plan of whether to remain in the facility or desire to discharge back to the community. The discharge plan of any upcoming potential discharges for the next seven days will be reviewed by the Discharge planner weekly and discussed in the Medicare/Medicaid meeting by the administrator, Discharge Planner, Therapy manager, assistant administrator, Director of Nursing, Social Worker and the MDS coordinator. In the Medicare/Medicaid meeting, upcoming or potential discharges through the next seven days are discussed and care plans are updated at this time. The potential discharges discussed are evaluated the interdisciplinary team including but not limited to; home health, primary care physician, durable medical equipment needs, any services needed from the community, education for medication management, treatments, food and dietary needs, care needs of activities of daily living and level of supervision needed. During the Medicare/Medicaid meetings, the interdisciplinary team reviews the progression of each resident and projected discharge date based upon safety and resident goals. The Director of Nursing or Assistant Director of Nursing brings information for any residents with a change in condition according to information gathered from Unit Managers and Charge Nurses. These residents are reviewed at this time for any significant changes that may affect an upcoming discharge.

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Any change of condition including discharge information is communicated to the resident or resident representative and provider by the Discharge Planner, nurse and/or Unit Manager. The interdisciplinary team consists of at least the Director of Nursing, Social Worker, Dietician, Therapy Director, and Nursing MDS Coordinator. The Director of Nursing communicates any potential discharge residents to the Unit Coordinator/Manager to initiate training/teaching to resident or resident representative when applicable. This includes but is not limited to; blood sugar checks, insulin administration, wound care, tube feedings, oxygen therapy, and medication management. The providers are also included in the discussions of potential discharges and address safety and medical needs. The Social Worker and/or Discharge Planner are responsible for communicating with the resident and family representative on discharge needs including community resources for potential discharges. The Dietician is responsible for education on dietary needs related to their diagnosis. The Therapy Director is responsible for the oversight of the treating therapist, to ensure resident meets goals for safe discharge and any barriers to discharge are communicated to the team for follow up. If a home visit is applicable based on discharge needs, the Therapy Director will be responsible for coordination. The Therapy Director will also coordinate caregiver training where applicable and ensure completion. The Nursing MDS Coordinator reviews each resident for clinical needs at the facility and also ensuring the resident has appropriate follow up based on medical needs for discharge. Resident and family representatives are then notified by the Discharge Planner of future discharge date and

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will assist with discharge follow up needs. The discharge planner updates the discharge care plan as needed.
The nursing staff will document the discharge instructions given to the resident and/or resident representative upon discharge. This process will be reviewed prior to discharge by the Director of Nursing as noted with the discharge audit. The provider will complete a discharge summary after visiting resident to include discharge plan for resident and ensure medical needs are met prior to discharge.
On October 30, 2018, the Regional Vice President of Operations for the contracted therapy company educated all facility Rehab Directors via telephone regarding the importance of home visits when needed to determine a resident's safety or additional safety needs post discharge from the facility. The discharge planner and/or therapy manager is responsible for determining the need of a home visit for all discharged residents and assigning the staff member that will go out to the home. When a home visit is deemed necessary for resident safety, it is completed prior to the discharge home.
Beginning January 2, 2019, the Assistant Administrator, Director of Nursing, and Assistant Director of Nursing provided in-servicing for all staff, including the discharge planner and discharging nurse, regarding abuse and neglect of residents. This was completed by January 4, 2019.
Beginning December 14, 2018, a resident's discharge planning will begin at the time of admission. The discharge planner, and/or therapy director will speak with the resident and/or representative within 72 hours of admission to determine discharge needs. The needs

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determined will include discharge disposition, needs of the home such as stairs or other impediments, follow up physician needs, pharmacy preferences, home health preferences, and care needs. These needs will continue to be discussed amongst the social worker, discharge planner, therapy director, and nurse management throughout the stay and leading up to discharge at least weekly and with change in condition. Resident and/or representatives will be notified of any changes that take place by the Discharge Planner from the initial discharge plans or if a home visit is needed to assess safety.
The Director of Nursing educated all nurses, including the treatment nurse, dietary manager, therapy manager, activity director, and social workers on December 17, 2018 and completed by December 28, 2018. This in-service included; family representative training to ensure understanding of discharge instructions, notification of change in condition, including but not limited to, newly acquired wounds or change in condition of a resident's skin, development and implementation of a care plan, and discharge planning process. The nurses and social workers were educated to document all discharge planning including training given prior to discharge. Any nursing staff and/or social worker that did not receive this in-servicing on December 17, 2018 were not allowed to work until in-servicing was completed. This in-service was 100% complete on December 28, 2018.
In-servicing for Abuse and Neglect policies will be included in the new staff orientation and also in annual training of existing staff. This in-servicing will be provided by the Administrator, Assistant Administrator, Director of Nursing and/or Staff Development Coordinator; including but not limited to education/training regarding unsafe

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F 624	Continued From page 15 discharges. The facility plans to monitor its performance to make sure that solutions are sustained. Beginning December 18, 2018, the Director of Nursing began completion of a daily discharge audit tool. This tool is used to ensure proper documentation post discharge including, but not limited to; resident's comorbidities, mental status, education of treatments, destination, and disposition of resident's personal properties upon discharge. This tool will be completed weekly for a minimum of three months and then a minimum of monthly for one year. Results of these audit tools will be presented to the QAPI committee by the Director of Nursing for any changes or outcome resolutions. On December 14, 2018, the Assistant Administrator began a discharge planning audit tool. This tool involves reviewing the medical record prior to discharge to ensure the discharge planner documented discharge needs and involvement of caregivers and interdisciplinary team in conducting a safe discharge plan. It allows the facility to ensure all agencies required for post discharge are ordered timely and are documented in the resident's record. This tool was completed daily x 4 weeks and will continue to be completed weekly for a minimum of three months and then a minimum of monthly for one year. The assistant administrator calls each newly discharged resident and/or representative to ensure all discharges were properly prepared and implemented to include; review of medication listings, transportation method was appropriate, home health initiation occurred, wounds treatment education if applicable was provided, and any other education needed related to residents' medical needs was provided.	F 624		

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F 624	Continued From page 16 Reassurance is made of no concerns or issues at the time and ensures resident or caregiver has a call back number if needed. Results of these audit tools will be presented to the QAPI committee by the Assistant Administrator for any changes or outcome resolutions. The assistant administrator will monitor that each resident has a discharge plan on admission and ensure that the plan is reviewed and revised as needed. " Compliance date was 1/4/19 The credible allegation was verified via staff interviews and record reviews on 2/8/19 and as evidenced by the following: verification of re-education for discharge planner, social worker and licensed nurses. All staff interviewed (nursing and non-nursing staff, administrative staff) as appropriate stated new processes for discharge and abuse/neglect Staff training and in-services. Review of audits. Review of documentation for resident discharge of a resident including stand-up meeting, assessment, discharge began at admission, discharge summary, medication release form and discharge instructions, validated staff reviewed resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge. The facility's compliance date was verified as 1/4/19.	F 624		
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	F 660		2/22/19

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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 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.

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F 660	Continued From page 18 (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, family member, van driver, home health staff and facility staff interview the facility failed to address Resident #1's care needs (medications, activities of daily living, and pressure sore management), the type of caregiver support and the logistics of assuring that the resident had the equipment and support required. The facility did not have a comprehensive care plan that addressed discharge. The facility discharged Resident #1 to	F 660	Past noncompliance: no plan of correction required.	

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home despite failing to address and acknowledge family members' voiced concerns of being unable to care for Resident #1 at home. This was evident in 1 of 4 residents reviewed for discharge planning (Resident #1).
The findings included:
Resident #1 was admitted to the facility on 8/28/18 after a recent hospital course for a left hip hemiarthroplasty (replacement of half of the hip joint) due to a fall at home that resulted in a left femoral fracture. The resident's cumulative diagnoses included diabetes, heart failure, hypertension and cerebral infarction.
Review of a 48-hour interim care plan for Resident #1 dated 8/28/18 revealed a goal that resident would have a smooth transition to home/assisted living facility. Approaches included to initiate discharge planning, provided resident/representative with information regarding community resources and educate resident/representative on services provided in the facility.

Review of the 14-day Minimum Data Set (MDS) dated 9/11/18 coded the resident with severely impaired cognition. The MDS indicated Resident #1 required extensive assistance of 2 people for bed mobility, total assistance of 2 people for transfer, and required extensive assistance of one person for dressing, eating, toilet use, personal hygiene and bathing. The MDS indicated Resident #1 was incontinent of bowel and bladder. The resident's balance was coded as steady only when stabilized with staff assistance and her mobility device was a wheelchair. Resident #1 was coded as expected discharge to the community.
A review of the comprehensive care plan dated 9/12/18 did not include a care plan for discharge

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planning.
A review of the treatment progress note dated 9/17/18 revealed Resident #1 had a newly acquired inhouse identified unstageable pressure sore to the left buttock. An unstageable pressure sore has full thickness tissue loss in which the base of sore is covered by slough and/or eschar in the wound bed. Review of the wound assessment report dated 9/17/18 and 9/24/18 revealed this an inhouse pressure sore to the left buttock measured 1.2 centimeters (cm) in length by 1.5 cm in width, no measurable depth with 100% slough tissue. There was no further assessment of the pressure sore prior to discharge.
Review of a Discharge Planner (DP) note dated 9/21/18 for Resident #1 stated the Social Worker (SW) had informed the responsible party (RP) that Resident #1 last day of Medicare coverage was 9/28/18. The SW explained the non-coverage letter, advanced beneficiary notice letter and appeal process and rights to the resident. Review of a departmental note dated 9/28/18 revealed Resident #1 was scheduled to be discharged home on 9/28/18 with her family. Home health had been arranged, no equipment was determined to be needed and the family was to arrange for a follow up visit with her primary care physician.
A review of discharge paper work dated 9/28/18 for Resident #1 revealed no documentation related to treatment of the resident's pressure ulcer or information about the prescribed medications.
Review of a departmental note authored by the DP dated 10/3/18 at 4:53pm stated "Called (family) and left message that I (DP) needed to speak with family as soon as possible that the patient was not picked up on discharge date and

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that we will be transporting patient home soon, so they needed to call my personal cell #/am."
Review of the nurse progress notes dated 10/3/18 and 10/4/18 revealed resident took medications crushed and placed in pudding.
An interview on 2/6/19 at 11:56 am with the Treatment Nurse (TN) stated "I do not know the status of the wound (referring to the pressure sore) when she was discharged and did not educate the family about how to care for the wound. The incision site also had drainage.
Further interview revealed the home health agency would perform the dressing changes.
Interview on 2/6/19 at 12:40 pm with the Administrator revealed no facility staff accompanied resident home and it was his expectation that staff follow the regulations (was not specific) for discharging residents home.
Interview on 2/6/19 at 1:21 PM with the DP who stated the Medicare non-coverage for Resident #1 was in effect on 9/28/18. The RP stated to her that they could not afford private pay so Resident was to be discharged to her home on 9/28/18. Further interview revealed the family had at home a handicap van, hospital bed and wheelchair. DP stated no one called and no one came to pick Resident #1 up on 9/28/18. On 10/1/18 she spoke with a family member on 10/4/18 who requested transportation and she refer them to a private van service. "I then called them (referring to the van service) to transport the resident on 10/4/18." DP stated she was unaware of the teaching/preparation of the discharge. Home Health Agency #1 was the agency that approved Resident #1's admission for home care.
An interview on 2/6/19 at 2:20 PM with Nurse #10 indicated she administered the resident's medications crushed and mixed with pudding, required total care and was fragile. Nurse #10

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stated "I gave no instructions because the resident went home with home health services." Nurse #10 indicated she had completed the discharge paper work on 10/4/18 for Resident #1. She stated she discharged the resident to no one and was told to complete the paper work (did not identify who gave her instructions). Nurse #10 stated she never saw a medication list or prescriptions to send home with the resident. She added home health was scheduled to be in the home the next day. Further interview with Nurse #10 indicated 10/4/18 was the only day she had worked with this resident and she really didn't know much about her. She stated normally when she discharged a resident there was a family member present and she would review all of the medications and appointments with them. Nurse #10 added she didn't see any treatment orders for Resident #1's pressure sore. She stated this was not the normal process for discharging a resident.

An interview via the phone on 2/6/19 at 7:14 PM with a family member indicated she had informed the facility that they (referring to the family) had no means to take care of Resident #1. She stated on 10/4/18 the facility called again and the next thing we knew Resident #1 was dropped off by a van. This family member indicated they had no medications except insulin for the resident and they had no knowledge that the resident had a pressure sore on her buttock. The family member stated the facility just dumped Resident #1 off without any instructions on how to take care of her. She added the resident was placed in another nursing home. Continued interview revealed "I received only one sheet of paper. The family member continued to indicate the family did not have all the medications to administer and had told the facility that they could not take care

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of her at home due to inability to lift and move Resident #1. Further interview revealed the home care nurse called the pharmacy to get the medications and she "Tried talking to (DP) who was rude and told us we had no choice but to bring her home."
An interview on 2/6/19 at 2:30 pm with Nursing Assistant (NA) #11 stated resident required total care for all activities of daily living, fed herself finger foods but staff needed to feed her. Resident was incontinent of urine and stool and would require 2 people to transfer her to the toilet. She needed staff to turn her at least every 2-3 hours and position her with pillows on her right side due to leaning.
An interview on 2/6/19 at 3:30 pm with Home Health Agency (HHA) Nurse #1 and HHA Nurse #2 (nurse who conducted the initial evaluation on 10/5/18) was conducted via the phone. HHA Nurse #2 stated on arrival on 10/5/18 at 1:06 pm to the resident's home, Resident #1's brief, clothing and bed sheets were soaked with urine. She also experienced an incontinent episode of bowels. HHA Nurse #2 stated Resident #1 expressed to her that she was hungry and had not eaten all day. A family member then brought Resident#1 a pop tart and walked into and out of the room. There was no set up date for a follow-up with the physician nor were there any medications. HHA Nurse #2 stated she called the pharmacy for medication to be delivered and set up an appointment to the MD office. Additionally, there was no glucometer or strips to test the resident's blood glucose level. HHA Nurse #2 indicated by 10/24/18 Resident #1 was transferred to another skilled facility.
An interview on 2/7/19 at 12:23 PM with the Transportation company (TC) van driver indicated a family member (No name provided) was

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present when he arrived at the home. The van driver stated he brought the Resident's personal belongings and a "discharge packet". TC van driver stated no facility staff accompanied the resident and a family member transferred the resident to bed so that he could return the facility's wheelchair.
Interview on 2/8/19 at 9 AM with the Physical Therapist (PT) revealed on the initial screening resident was maximal assist for bed mobility and did not have good body awareness due to previous stroke and limited motor skills. An inquiry was made about home visits and the PT therapist indicated that the rehab department does not conduct home visits and rely on the home health physical therapist to assess. The PT indicated the resident did not achieve her goals and needed maximal to moderate assistance from staff.
The facility implemented the following corrective action:
"Resident # 1 was admitted to Oak Forest Health and Rehabilitation on August 28, 2018 with diagnoses of hypertensive heart disease, Type 2 Diabetes Mellitus with Hyperglycemia, Presence of Left Artificial Hip Joint and Cerebral Infarction. Upon admission to facility, resident #1 was identified with Impaired Skin Integrity. A 48-hour interim care plan was completed on August 28, 2018 including discharge planning with goal of a smooth transition to home. Resident #1 received physician order for Occupational and Speech Therapy evaluations and treatments on August 28, 2018, and Physical Therapy evaluation and treatment on August 29, 2018. Resident received therapy services throughout her stay and required much encouragement to participate. On September 17, 2018 the facility Treatment Nurse discovered a pressure ulcer to Resident #1's left

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buttock. The Treatment Nurse completed the appropriate documentation for the pressure ulcer and notified resident's attending physician and Medical Director. New orders were received from the physician on September 18, 2018 for the treatment of the pressure ulcer. The treatment nurse did not notify the Resident Representative of the pressure ulcer. The discharge planning of Resident #1 included a referral for Home Health services to include PT, OT evaluation and treatment and nursing for treatment of sacral wound. The facility failed to do a home visit and evaluate any barriers in the home prior to discharge.

PT and OT services were discontinued on September 25, 2018 and ST services were discontinued on September 27, 2018. At this time resident had reached her maximum potential and an order on September 25, 2018 was received from the Medical Director to discharge resident home with family on September 28, 2018. On September 21, 2018 the discharge planner issued a Notice of Non-Coverage and discussed with Resident's Representative via phone call at 1:59 pm. Resident's Representative was notified of last covered day of skilled services to be on September 27, 2018. Resident's Representative verbalized understanding and confirmed the plan for resident to return home on September 28, 2018. Resident's Representative did not arrive to facility on September 28, 2018 to pick up Resident#1 as planned. At approximately 7pm, the charge nurse on duty notified the facility Administrator that the family had not picked resident up. The administrator instructed that facility would hold off on discharge and revisit issue on Monday, October 1, 2018. On October 1, 2018, the facility Social Worker attempted to contact Resident Representative and was unable

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to reach him. Social Worker then contacted second family member and left messages to return call. The second family member called Social Worker back on October 4, 2018 and requested for facility to transport Resident #1 home. Transportation was notified and agreed to transport resident and bill family for cost of transport. Resident was picked up at facility on October 4, 2018 and taken home and received by Resident Representative. Resident's discharge instructions including information regarding Home Health agency was given to Resident Representative at time of transport.
The facility failed to provide and document sufficient preparation and orientation to resident representative to ensure safe and orderly discharge from the facility. The family representative did not have knowledge of the resident's wound and treatment for the wound or that the left hip surgical incision site had small amount of drainage. The nurse failed to provide and review a medication list and medication prescriptions with family representative. Family training and documentation was not completed.
On October 4, 2018, the facility failed to train a family representative of Resident #1's medical condition including; wound care treatment/surgical incision drainage, medication listing review, and medication prescriptions, type of diet resident needed, level of supervision and ADL assistance needed prior to Resident #1's discharge home. The discharge planning of Resident #1 did include a referral for Home Health services to include PT, OT evaluation and treatment and nursing for treatment of sacral wound.
Corrective action accomplished for those residents found to have been affected by the deficient practice.

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Resident #1 was discharged from the facility on October 4, 2018. At the time of this compliance, Resident #1 is residing in another skilled nursing facility.
Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
Starting December 13, 2018, the facility completed a 100% audit of all residents discharged within the last two weeks prior to the start of the original plan of correction regarding Resident #1. This audit included sixteen residents and no negative findings were found. This audit was completed on 12/14/18 and was to ensure the facility implemented an effective orientation, preparation, and transition to post-discharge care including education of medications and residents' medical treatment needs.
By failing to provide a family representative with a review of Resident #1's wound treatment, medication listing, and medication prescriptions, this is considered neglect according to regulation.
The discharge planner and nurse involved with Resident #1's discharge was educated on December 6, 2018 by the Administrator and Director of Nursing. The in-servicing included, but was not limited to; notification of changes, development, preparation, and implementation of a comprehensive care plan for discharge, as well as a preparation and implementation of the discharge planning process. The Director of Nursing, Assistant Director of Nursing, assistant administrator gave an in-service to all staff, including but not limited to the discharge planner, social worker and nurses starting January 2, 2019 and completed by January 4, 2019. The in-service included Abuse and Neglect education.
A 100% audit was completed utilizing a

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comprehensive care plan tool starting on 12/19/18 and completed on 12/20/18 of all current residents residing in the facility to ensure each resident had a discharge care plan. This audit was completed by Discharge Planner and Director of Nursing. Discharge Planner and Director of Nursing ensured the current care plan matched the discharge plan for each resident. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Upon admission, the discharge plan process is initiated. The interim care plan is initiated on admission by the admitting nurse and completed by the RN Unit Manager, Assistant Director of Nursing, and Director of Nursing. All nurses were educated by the Director of Nursing on December 17, 2018 about the requirement of the facility to develop and implement a care plan for each resident including the discharge plan. The interim care plan includes the discharge plan of whether to remain in the facility or desire to discharge back to the community. The discharge plan of any upcoming potential discharges for the next seven days will be reviewed by the Discharge planner weekly and discussed in the Medicare/Medicaid meeting by the administrator, Discharge Planner, Therapy manager, assistant administrator, Director of Nursing, Social Worker and the MDS coordinator. In the Medicare/Medicaid meeting, upcoming or potential discharges through the next seven days are discussed and care plans are updated at this time. The potential discharges discussed are evaluated the interdisciplinary team including but not limited to; home health, primary care physician, durable medical equipment needs, any services needed from the community, education for medication management, treatments, food

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and dietary needs, care needs of activities of daily living and level of supervision needed. During the Medicare/Medicaid meetings, the interdisciplinary team reviews the progression of each resident and projected discharge date based upon safety and resident goals. The Director of Nursing or Assistant Director of Nursing brings information for any residents with a change in condition according to information gathered from Unit Managers and Charge Nurses. These residents are reviewed at this time for any significant changes that may affect an upcoming discharge. Any change of condition including discharge information is communicated to the resident or resident representative and provider by the Discharge Planner, nurse and/or Unit Manager. The interdisciplinary team consists of at least the Director of Nursing, Social Worker, Dietician, Therapy Director, and Nursing MDS Coordinator. The Director of Nursing communicates any potential discharge residents to the Unit Coordinator/Manager to initiate training/teaching to resident or resident representative when applicable. This includes but is not limited to; blood sugar checks, insulin administration, wound care, tube feedings, oxygen therapy, and medication management. The providers are also included in the discussions of potential discharges and address safety and medical needs. The Social Worker and/or Discharge Planner are responsible for communicating with the resident and family representative on discharge needs including community resources for potential discharges. The Dietician is responsible for education on dietary needs related to their diagnosis. The Therapy Director is responsible for the oversight of the treating therapist, to ensure resident meets goals for safe discharge and any barriers to discharge are

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communicated to the team for follow up. If a home visit is applicable based on discharge needs, the Therapy Director will be responsible for coordination. The Therapy Director will also coordinate caregiver training where applicable and ensure completion. The Nursing MDS Coordinator reviews each resident for clinical needs at the facility and also ensuring the resident has appropriate follow up based on medical needs for discharge. Resident and family representatives are then notified by the Discharge Planner of future discharge date and will assist with discharge follow up needs. The discharge planner updates the discharge care plan as needed.

The nursing staff will document the discharge instructions given to the resident and/or resident representative upon discharge. This process will be reviewed prior to discharge by the Director of Nursing as noted with the discharge audit. The provider will complete a discharge summary after visiting resident to include discharge plan for resident and ensure medical needs are met prior to discharge.

On October 30, 2018, the Regional Vice President of Operations for the contracted therapy company educated all facility Rehab Directors via telephone regarding the importance of home visits when needed to determine a resident's safety or additional safety needs post discharge from the facility. The discharge planner and/or therapy manager is responsible for determining the need of a home visit for all discharged residents and assigning the staff member that will go out to the home. When a home visit is deemed necessary for resident safety, it is completed prior to the discharge home.

Beginning January 2, 2019, the Assistant

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Administrator, Director of Nursing, and Assistant Director of Nursing provided in-servicing for all staff, including the discharge planner and discharging nurse, regarding abuse and neglect of residents. This was completed by January 4, 2019.

Beginning December 14, 2018, a resident's discharge planning will begin at the time of admission. The discharge planner, and/or therapy director will speak with the resident and/or representative within 72 hours of admission to determine discharge needs. The needs determined will include discharge disposition, needs of the home such as stairs or other impediments, follow up physician needs, pharmacy preferences, home health preferences, and care needs. These needs will continue to be discussed amongst the social worker, discharge planner, therapy director, and nurse management throughout the stay and leading up to discharge at least weekly and with change in condition. Resident and/or representatives will be notified of any changes that take place by the Discharge Planner from the initial discharge plans or if a home visit is needed to assess safety.

The Director of Nursing educated all nurses, including the treatment nurse, dietary manager, therapy manager, activity director, and social workers on December 17, 2018 and completed by December 28, 2018. This in-service included; family representative training to ensure understanding of discharge instructions, notification of change in condition, including but not limited to, newly acquired wounds or change in condition of a resident's skin, development and implementation of a care plan, and discharge planning process. The nurses and social workers were educated to document all discharge planning including training given prior to

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discharge. Any nursing staff and/or social worker that did not receive this in-servicing on December 17, 2018 were not allowed to work until in-servicing was completed. This in-service was 100% complete on December 28, 2018.
In-servicing for Abuse and Neglect policies will be included in the new staff orientation and also in annual training of existing staff. This in-servicing will be provided by the Administrator, Assistant Administrator, Director of Nursing and/or Staff Development Coordinator; including but not limited to education/training regarding unsafe discharges.
The facility plans to monitor its performance to make sure that solutions are sustained.
Beginning December 18, 2018, the Director of Nursing began completion of a daily discharge audit tool. This tool is used to ensure proper documentation post discharge including, but not limited to; resident's comorbidities, mental status, education of treatments, destination, and disposition of resident's personal properties upon discharge. This tool will be completed weekly for a minimum of three months and then a minimum of monthly for one year. Results of these audit tools will be presented to the QAPI committee by the Director of Nursing for any changes or outcome resolutions.
On December 14, 2018, the Assistant Administrator began a discharge planning audit tool. This tool involves reviewing the medical record prior to discharge to ensure the discharge planner documented discharge needs and involvement of caregivers and interdisciplinary team in conducting a safe discharge plan. It allows the facility to ensure all agencies required for post discharge are ordered timely and are documented in the resident's record. This tool was completed daily x 4 weeks and will continue

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to be completed weekly for a minimum of three months and then a minimum of monthly for one year. The assistant administrator calls each newly discharged resident and/or representative to ensure all discharges were properly prepared and implemented to include; review of medication listings, transportation method was appropriate, home health initiation occurred, wounds treatment education if applicable was provided, and any other education needed related to residents' medical needs was provided. Reassurance is made of no concerns or issues at the time and ensures resident or caregiver has a call back number if needed. Results of these audit tools will be presented to the QAPI committee by the Assistant Administrator for any changes or outcome resolutions. The assistant administrator will monitor that each resident has a discharge plan on admission and ensure that the plan is reviewed and revised as needed.
The Director of Nursing and/or Assistant Director of Nursing will bring a list of all new admissions along with the medical record of each to the daily stand up meeting. The residents' records will be reviewed by the DON/ADON to ensure that all new admissions are reviewed to ensure the Interim Care plan including but not limited to the discharge plan, is completed. All projected plans for a discharge in the next 7 days, will be reviewed and revised by the IDT team weekly in the Medicare/Medicaid meeting."
Completion date: 1/4/19
The credible allegation was verified via staff interviews and record reviews on 2/8/19 and as evidenced by the following: verification of re-education for discharge planner, social worker and licensed nurses. Staff training and in-services Review of audits. All staff interviewed (nursing and non-nursing staff, administrative staff) as

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F 660	Continued From page 34 appropriate stated new processes for discharge and abuse/neglect Review of documentation for resident discharge of a resident including stand-up meeting, assessment, discharge began at admission, discharge summary, medication release form and discharge instructions, validated staff reviewed resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge. Based on the verification the facility compliance was achieved on 1/4/19.	F 660		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview with the consultant pharmacist, staff interview and review of the manufacturer's literature, the facility failed to follow the manufacturer's instructions to remove a previously applied transdermal patch before the application of a new one. This was evident in 1 of 3 residents reviewed with physician orders for a transdermal patch. (Resident #6). The findings included: Review of the manufacturer's instructions	F 684	Oak Forest Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 3/8/19. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure	3/8/19

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F 684	Continued From page 35 revealed the previously applied Neupro transdermal patch placed on the skin must be removed before the application of a new one. Resident #6 was admitted from a recent hospital stay to the facility on 1/7/19 with cumulative diagnoses which included Parkinson's disease. Record review revealed on 1/21/19 a physician order for Neupro 2 milligrams (mg) transdermal patch every 24 hours for two (2) weeks then increase to 4 mg every 24 hours which was based on the neurologist recommendation. Neupro is used to treat Parkinson's disease by decreasing tremors and stiffness. Review of the E-Medication Administration Record revealed a Neupro 2 mg patch was applied to the resident's skin on 1/22/19 and 1/23/19. Record review revealed a written grievance dated 1/24/19 regarding two (2) Neupro patches dated 1/22/19 and 1/23/19 found on Resident #6. Review of the investigation dated 1/25/19 revealed Nurse #14 failed to remove the transdermal patch dated 1/22/19 before applying a new patch on 1/23/19. Interview on 2/7/19 at 3:17 PM with Nurse #14 who stated she placed the new patch on without removing the old one. "I meant to go back and remove the previous one, it was an oversight." Interview on 2/7/19 at 4:57 PM with the Administrator revealed the 1st patch (dated 1/22/19) should have been removed. The Director of Nurses (DON) joined the conversation	F 684	continuing compliance with Federal and State regulatory law. The facility nurse failed to follow the manufacture's literature instructions to remove a Neupro patch applied on 1/22/19 prior to application of a new patch on 1/23/19. The nurse was educated on 1/25/19 by the Director of Nursing in regards to the Neupro patch not being removed. The affected resident was not residing in the facility at the time of the plan of correction. The facility conducted a 100% audit of all residents with patches on 2/7/19 during the survey. Another 100% audit of all current residents will be completed by 3/4/19. 100% of all nurses and medication aides will be educated on proper placement and removal of topical patches by 3/8/19. Nurses and medication aides will also be educated on practices to reduce medication errors by 3/8/19. The Unit Manager and Unit Coordinator will continue to complete second checks to ensure physician orders are properly keyed in the computer. The Unit Manager, Unit Coordinator, nurses, and medication aides will notify the Director of Nursing immediately of any medication errors. Medication Patch Audits will be used to ensure proper placement and removal following manufacturer's instructions daily x 4 weeks, weekly for 3 months and monthly x 1 year. The Director of Nursing will present the results of the audit tools to	

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F 684	Continued From page 36 via the phone who indicated Nurse #14 just forgot to take off the previous patch. The DON stated, "We educated her on how to administer the patch and remove the old patch prior to applying the new patch." Interview on 2/8/19 at 10 AM via the phone with the consultant pharmacist who stated that the manufacturer's instructions stated to remove the previous patch before the application of a new one.	F 684	the Monthly QAPI committee meeting for 1 year. The Director of Nursing, Unit Manager, Unit Coordinator, and RN Staff Development Manager will implement the above corrective actions.	