STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	C 09/19/2019

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MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/18/19 through 09/19/19. There were a total of 5 allegations investigated and all were unsubstantiated.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the	F 626		10/17/19

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

Electronically Signed | 10/10/2019

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F 626	Continued From page 1 composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview the facility failed to allow a resident to return to the facility after a 4-hour therapeutic leave for 1 of 3 resident reviewed for safe and orderly discharge (Resident #2). The findings included: Review of a Discharge Summary from the local hospital dated 07/18/19 indicated Resident #2 was being discharged from the hospital to the skilled nursing facility. The Summary further indicated that Resident #2 required on going wound care and the use of oral antibiotics for his wounds. Resident #2 was admitted to the facility on 07/18/19 with diagnoses that included bilateral lower extremity cellulitis, acute chest pain, acute lower gastrointestinal bleed, chronic venous stasis ulcers, and esophageal adenocarcinoma No current Minimum Data Set (MDS) information was available for Resident #2. Review of a facility document titled "Admission Note" 07/18/19 at 8:45 PM read, Resident #2 arrived at the facility today at 3:45 PM via transportation from the local hospital. "Once he arrived and was escorted to his assigned room, he communicated with therapy that he needed to leave and go back to his hotel room for his	F 626	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F626 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 has successfully transitioned home with home health and follow up with the wound clinic. How the facility will identify other residents having the potential to be affected by the same deficient practice. No other residents were identified as having the potential to be affected by the same deficient practice.	

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F 626	Continued From page 2 personal belongings." "It was decided that he could go but had two hours to return and complete his admission process." "Shortly after he signed out and left he was seen at a local bar consuming alcohol." "He was instructed to return to the facility to complete his admission process and re-educated on the 2 hour window rule he was given." "After over 4 hours of being away from the facility he returned to the front door." "He was alert and oriented and at that time he was instructed that he could not be admitted due to the time lapse from" the local hospital to this facility. This writer witnessed the resident schedule a lyft (personal cab service) rider and leave the premises with all of his belongings. The admission note was signed by Nurse #1. Review of facility document titled "Resident Sign out Log" dated 07/18/19 indicated that Resident #2 signed himself out of the facility at 4:00 PM. No time of return was noted. An interview was conducted with Resident #2 on 09/18/19 at 10:53 AM. Resident #2 stated that on 07/18/19 an ambulance brought him to the facility from the local hospital and he walked into the facility and was greeted by the staff. He stated that he had been a resident at the facility several months ago, so the staff were familiar with him and were glad to see him and welcomed him back. Resident #2 stated that the staff escorted him to his private room, and he notified them that he needed to go across town to his hotel room where he had lived for a year and half and gather his personal belongings. He added that in the year and a half that he has resided at the hotel he has had a home health agency that came in 2-3 times a week to complete his wound care and weekly he walked to the wound clinic. If the	F 626	The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Facility nursing staff educated that a patient arriving to the facility seeking admission cannot leave the facility on a leave of absence until his or her admission assessment has been completed; nevertheless, if a resident demands to leave the facility, as is his or her right, then they must sign out of the facility against medical advice completed by October 16, 2019. Facility nursing staff also educated on the facility policy for leave of absence; completed by October 16, 2019. The Director of Nursing or designee will audit residents who take a therapeutic leave of absence for re-entry to the facility. The audit will review any residents on a leave of absence since the last audit up to a random sample of 5 residents. The audit will assess leave of absence residents for re-entry to the facility 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months to ensure deficient the practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with a resident s re-entry after an appropriate leave of absence will receive progressive discipline.	

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F 626	Continued From page 3	F 626		

weather was bad Resident #2 stated, he would call a lyft ride to get him to and from his appointments at the wound clinic. At that point Resident #2 stated Nurse #1 told him that he could go across town and get his belonging, but he needed to be back in 2 hours. Resident #2 stated that he signed himself out of the facility at 4:00 PM and walked across the street to a local restaurant to wait for his friend that was going to give him a ride to his hotel room. While Resident #2 was sitting at the restaurant he ordered a beer and was waiting on his friend when the facility's Business Office Manager (BOM) approached him and asked if he was coming back to the facility. Resident #2 replied, yes I am, I am just waiting on my ride to take me to get my belongings. Resident #2 stated that he learned his friend was not coming until later, so he stated he called a lyft ride who took him to the hotel to gather his belongings and brought him back to the facility at around 8:00 PM. Resident #2 stated that when he returned to the facility at 8:00 PM Nurse #1 came to the door and told him he was not allowed back in the facility because it had been longer than the 2 hour time frame he was given when he left. He added that when Nurse #1 would not let him in the facility he had no choice to but to get back in the lyft ride and return to his hotel room. He denied being intoxicated and stated he had a beer but was certainly not drunk. Resident #2 confirmed that he did not have his new medication that had been prescribed in the hospital and no instructions were sent with him when he left to go get his belongings. He also confirmed that he intended to and did return to the facility but was not allowed to enter the building. Resident #2 stated that when he returned to his hotel room, he did not have his medication and had no wound care but stated he

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F 626	Continued From page 4	F 626		

contacted the Home Health agency that had previously been visiting him several times a week and they were able to resume their schedule. He added that he also reported to the wound clinic once a week as he was previously accustomed to and was doing well at the present.

An interview was conducted with the BOM on 09/18/19 at 11:52 AM. The BOM stated that on 07/18/19 he was advised that Resident #2 would be readmitting to the facility as skilled patient. He added that once he was advised that Resident #2 would be admitted to the facility, he proceeded to verify his insurance benefits and confirmed with the Administrator that he was ok to return to the facility despite owing the facility some money from his previous stay in May 2019. The BOM stated less than an hour after Resident #2 arrived at the facility on 07/18/19 he was made aware that Resident #2 was across the street at a local restaurant consuming alcohol. He indicated he went over to the restaurant to confirm this and found Resident #2 with a mixed beverage and a beer. The BOM stated he asked Resident #2 to return to the facility and complete his admission and Resident #2 stated he would return to the facility, but it would be later because he needed to go across town and gather his personal belongings. The BOM manager stated that was the end of his involvement with Resident #2 as he left work for the day at 5:00 PM and Resident #2 had not returned yet.

Attempts to speak to Nurse #1 on 09/18/19 and 09/19/19 were unsuccessful.

An interview was conducted with the Admissions Director (AD) on 09/18/19 at 12:45 PM. The AD stated on 07/18/19 she greeted Resident #2 at

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F 626	Continued From page 5	F 626		

the entrance to the facility and escorted him to the nurse's station and Nurse #1 who took Resident #2 to his room. She stated that Resident #2 was adamant about going across town to gather his personal belongings with the intentions of returning to the facility after that. The AD stated that the interim Director of Nursing (DON) had given Resident #2 a 2-hour time frame to be back to the facility and she heard that when he returned well after the 2 hours he appeared to be intoxicated. She added that when Resident #2 returned to the facility she was gone, and he was not admitted to the facility to her knowledge.

An interview was conducted with the Social Worker (SW) on 09/18/19 at 1:13 PM. The SW confirmed that she also served as the discharge planner for the facility. She stated that Resident #2 came to the facility on 07/18/19 and then left to go and get his belongings and returned to the facility later. The SW stated she had left the facility and was not sure why Resident #2 was not admitted to the facility.

An interview was conducted with the Administrator on 07/18/19 at 1:20 PM. She stated that Resident #2 was a resident at the facility earlier in the year and had successful discharged to his long term stay hotel. She stated that in July 2019 they received a call from the local hospital stating that Resident #2 needed to readmit to the facility, and we said sure. The Administrator stated that about 10 to 15 minutes after Resident #2 arrived at the facility on 07/18/19 he stated he needed to run to his hotel room, and he would come right back. She added that the BOM had ordered lunch from the restaurant across the street and saw Resident #2 drinking alcohol and instructed him to return to the facility. She added

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that the nursing staff called and reported that Resident #2 had returned to the facility after 8:00 PM and was intoxicated and yelling and screaming and so we declined to admit him to the facility. The Administrator stated that Resident #2 did not want to be admitted and left on his own accord against medical advice, but no paper had been signed because Resident #2 had not technically admitted to the facility. She further stated that if Resident #2 was able to walk across the street to the restaurant and order a beer and run errands he did not require skilled care.

An interview was conducted with the Interim Director of Nursing (DON) on 07/18/19 at 2:50 PM. The Interim DON stated that she had received an unusual phone call from Resident #2 prior to him arriving at the facility, she stated that Resident #2 indicated his personal belongings were at a hotel and he needed to go and get them. The Interim DON stated she told Resident #2 that he could go and get his things and return to the facility in a reasonable amount of time of 2 hours. The Interim DON stated she reported to the nursing staff that she had given Resident #2, 2 hours to get his things and return to the facility. She confirmed that it was Resident #2's intent to return to the facility after he gathered his personal items. She stated that from what she could recall Resident #2 returned to the facility after 8:00 PM and was intoxicated and the staff did not admit him to the facility. The Interim DON confirmed that the staff had refused to admit Resident #2 away because he was intoxicated.

A follow up interview was conducted with the Administrator on 09/19/19 at 2:50 PM. The Administrator stated that Resident #2 was not formally admitted to the facility and when he left

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F 626	Continued From page 7 was given no discharge instructions because he was never admitted. She confirmed no discharge paperwork had been completed for Resident #2. An interview was conducted with the Case Worker (CW) from the local hospital on 09/19/19 at 3:36 PM. The CW stated that Resident #2 required skilled nursing care when he discharged from the hospital and the facility had agreed to provide that care for Resident #2 and on 07/18/19 he was transferred to the facility as agreed upon. The CW also stated that to her knowledge Resident #2 had not needed to return to the emergency room and had not been a patient in the hospital since his discharge on 07/18/19.	F 626		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident	F 661		10/17/19

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F 661	Continued From page 8 and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 closed record reviewed for a planned discharge (Resident #1). Findings included: Resident #1 was admitted to the facility on 07/15/19 with diagnoses which included generalized muscle weakness, heart disease, Type 2 diabetes and unspecified dementia. A review of an admission (14 day) Minimum Data Set dated 07/30/19 revealed Resident #1 was cognitively intact for daily decision making. The MDS also revealed Resident #1 required supervision with activities of daily living and received physical and occupational therapies. A review of a Physician's order dated 08/09/19 indicated Resident #1 was to discharge home with home health services. A review of a facility document titled Discharge Instructions/Plan of Care with a signed date of 08/12/19 by the Discharge Planner and Social Worker revealed there was no recapitulation of the resident's stay or a post discharge plan of care. The document indicated a section labeled	F 661	F661 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 has been discharged from the facility and requires no further follow up from the facility at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was conducted of all planned resident discharges from August 12, 2019 to present on October 7, 2019 with immediate staff education and a follow up call to the former resident on any incomplete information on the Discharge Instruction/Plan of care. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Interdisciplinary team, nursing, and therapy staff educated on completion of the facility Discharge Instruction/Plan of care process; completed by October 16, 2019. The	

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F 661	Continued From page 9 Follow up Physician Appointment but the section was blank. Further review of the document revealed a section titled Resident Medical Information was blank and a section titled Nursing Post-Discharge Plan for Care was blank. A review of a Nurse's note dated 08/13/19 revealed Resident #1 was discharged from the facility at 8:55 AM. During a telephone interview on 09/18/19 at 5:02 PM, a family member who stated he was Resident #1's responsible party explained after Resident #1 was sent home from the facility he got sick during the night so he took him to a local hospital emergency room around 4:00 AM. He stated he could not remember the date and he was not sure what was wrong with Resident #1 so he took him to the hospital for treatment. During an interview on 09/19/19 at 12:13 PM, Nurse #2 stated it was the usual process for Nurses to complete nursing sections of the discharge instructions and other departments were responsible to complete sections that pertained to them. She explained Nurses were supposed to document follow up Physician appointments on the discharge instructions and after review of Resident #1's discharge instructions she verified there should have been documentation to call and schedule a follow up appointment with a Physician. She explained documentation in the section labeled Nursing Post Discharge Plan of Care would vary depending on the resident's diagnoses but there should be documentation to indicate care the resident needed after discharge. During an interview on 09/19/19 at 3:52 PM, the	F 661	Director of Discharge Planning or designee will audit residents discharge instruction/plan of care assessments. The audit will review any residents discharged since the last audit up to a random sample of 5 residents. The audit will assess the discharge instruction/plan of care form for completeness 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months to ensure deficient the practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with completing the discharge instruction/plan of care assessment form prior to resident discharge will receive progressive discipline.	

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Discharge Planner and Social Worker explained different departments were expected to complete sections of the discharge instruction form. She confirmed she did not complete the follow up appointment information because Nurse's usually completed that information. She explained when it was time for a resident to be discharged, the discharge instructions were printed out and reviewed with the resident or a family member.

During a telephone interview on 09/19/19 at 11:23 AM, Nurse #3 stated she recalled Resident #1 was supposed to have been discharged on 08/12/19 but he did not go home that day. She further stated Resident #1 was ready for discharge on 08/13/19 and she reviewed medications he was supposed to continue at home and recalled he did not have any prescriptions that she needed to go over with him.

During an interview on 09/19/19 at 2:11 PM, the Unit Coordinator explained after review of Resident #1's Discharge Instructions/Plan of Care, the section for Physician follow up was blank. She stated she would have expected to see documentation to call and schedule a follow up appointment with the resident's primary care Physician. She further stated she would have also expected to have seen some documentation in the Medical Information section.

During an interview on 09/19/19 at 4:11 PM, the Director of Nursing explained Nurses were expected to complete the nursing sections of the discharge instructions. She stated it was her expectations for documentation to be accurate and complete.

During an interview on 09/19/19 at 4:19 PM, the

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F 661	Continued From page 11 Administrator explained it was her expectation for staff to use the Discharge Instruction/Plan of Care document as a guide to document discharge planning information.	F 661		