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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted onsite 04/14/2021 with exit from the facility on 04/14/2021. Additional information was obtained through 04/21/2021; therefore, the exit date was changed to 04/21/21. One allegation was investigated and substantiated. Event ID# OD1X11.	F 000		
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660		5/20/21

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

Electronically Signed | 05/14/2021

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representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the

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F 660	Continued From page 2 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interview, and Home Health Staff interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) had home health services and caregiver support when discharged from the facility. The facility also failed to determine Resident #1's access to medications and various rooms in his home, such as the bedroom and bathroom, in order for him to have a safe transition home. Resident #1 reported he remained in the wheelchair and defecated and urinated on himself until he called Emergency Medical Services two days after discharging due to pain on his bottom and was readmitted to the hospital. The findings included: The hospital history and physical progress note dated 02/28/21 read in part, Resident #1 "was brought by ambulance from his home to the Emergency Department (ED) today, one day after being released from a Skilled Nursing Facility (SNF), for evaluation of generalized weakness and inability to stand or walk. He was just discharged after a recent hospitalization on 02/05/21 to 02/11/21 with almost similar presentation. He was discharged from the hospital to the SNF for rehab and discharged yesterday." Resident #1 reported upon his discharge from the SNF, he was still unable to	F 660	An Ad Hoc QAPI Meeting was held on 4/16/21 to review the Facility Discharge Process by the Director of Nursing. All Citadel – Myers Park Residents have the potential to be affected by the deficient practice. A full house audit of all residents scheduled for discharge home, from therapy services, long term care within the facility, or to a different level of care outside of the facility has been conducted. An audit of residents who had been discharged within the past 30 days has also been conducted (4.16.21). To help ensure the deficient practice does not reoccur, the facility Interdisciplinary Care Plan Team, which includes nursing services, social work, therapy services, and dietary services, was reeducated on the Facility Discharge Process by the Director of Nursing. Education included discussing all pending discharges during the Department Head morning meeting (4.16.21). Each discipline including Social Work, Rehabilitation Services, and Nursing Services, was reeducated on their responsibilities regarding safe discharge from the facility which included	

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F 660	Continued From page 3 transfer or ambulate without significant assistance. He felt too weak to mobilize himself, stayed in the chair all night and this morning until home health arrived at his home and initiated his transfer back to the hospital today. Admitting diagnoses included: generalized weakness with significant weakness in bilateral lower extremities, acute kidney injury, chronic kidney disease, and atrial fibrillation. Resident #1 admitted to the facility on 03/05/21 with diagnoses that included acute embolism and thrombosis (blood clots formed in veins of the body) of deep veins of bilateral lower extremities, hypertension, anemia in chronic kidney disease, muscle weakness, and difficulty walking. Review of Resident #1's electronic medical record revealed he was listed as his own Responsible Party with no emergency contacts. The baseline care plan initiated 03/05/21 indicated Resident #1's initial discharge goal was to return to the community. The admission transfer and mobility evaluation assessment dated 03/05/21 noted Resident #1 was non-ambulatory with an unsteady gait, able to stand and pivot to transfer using a walker and sit on bedside with partial support (rail or person). The admission Minimum Data Set (MDS) dated 03/12/21 assessed Resident #1 with intact cognition for daily decision making. He required extensive assistance with bed mobility, transfers, dressing, toileting, locomotion off unit and personal hygiene. He used a wheelchair for mobility and his balance during transitions and walking was unsteady and only able to stabilize with human assistance. The MDS further noted	F 660	medication education, therapy services, and coordination of outside community services to help ensure a safe discharge. To help ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, the Director of Social Services will notify the Department Head Team of all pending discharges during morning meeting. The discussion will include, but not be limited to residents who are scheduled for discharge home, or to a different level of care outside of the facility. The facility interdisciplinary care plan team will review and discuss all discharges which will include, but not be limited to record review, notification to families and responsible parties, securing support services, prescriptions/medications, and hand offs to the next level of care or discharge location. Social services are responsible for notification and securing support services. For residents being discharged home alone, Social Services will ensure that residents will have community service support such as Home Health before discharge. Additionally, for residents discharging home with orders for equipment, the Interdisciplinary Team will determine which residents' homes require evaluations. Home evaluations will be conducted by Therapy Services prior to discharge. Evaluations will be conducted to assess the resident's abilities and difficulties in the home setting, as well as to provide for an opportunity to evaluate the physical environment to determine if	

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F 660	Continued From page 4 active discharge planning was in process. Resident #1's weight was documented as 418 pounds. Review of the social services progress notes for Resident #1 revealed the following: An entry dated 03/17/21 read in part, Social Worker (SW) spoke with Resident #1 regarding his discharge. Explained his insurance would no longer pay for his stay on 03/19/21. Discussed the appeal process and Resident #1 declined to appeal. SW discussed with Resident #1 that it was unsafe for him to return home at this time because he lived alone and required more care. Resident #1 stated he would like to stay but needed his income to pay his bills at home. Discussed discharge plans that would include Durable Medical Equipment (DME), home health and personal care services. An entry dated 03/18/21 read in part, Resident #1 requested the SW submit an appeal to his insurance company for a continued stay. An entry dated 03/22/21 read in part, SW and Resident #1 spoke with his insurance company and his rehab stay was extended to 03/27/21. An entry dated 03/23/21 read in part, Nurse Practitioner (NP) spoke with therapy staff and informed SW it was unsafe for Resident #1 to return home as he could not stand or transfer. SW informed NP that Resident #1's insurance extended his stay to 03/27/21. NP stated if Resident #1 decided to discharge, it would be Against Medical Advice (AMA) with no services such as home health, medication or DME. NP will talk with Resident #1 tomorrow about remaining in the facility. An entry dated 03/26/21 read in part, SW notified Resident #1 that per the DME company, his order for a wheelchair, sliding board and hospital bed	F 660	adaptations or modifications can be made to improve safety and overall functioning. Therapy Services will also offer Caregiver Training for resident discharging home with caregiver support. Training will include, but not be limited to bed mobility, gait training, stairway training, functional transferring, positioning, and strengthening. Results will be discussed and addressed during the facility's monthly Quality Assessment and Performance Improvement (QAPI) meeting. The date of compliance will be 5.20.21	

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would not be ready for discharge on 03/27/21. Resident #1 stated he wanted to go home tomorrow.
An entry dated 03/31/21 read in part, SW and Resident #1 spoke with the DME company and were informed a hospital bed in his size would not be available until 04/07/21 and they did not have bariatric wheelchair (chair widths ranging 30 inches to 36 inches wide) that could handle his weight and height. After the phone call ended, Resident #1 informed SW he would be discharging home before 04/07/21. SW will ask the Administrator if the facility could provide Resident #1 with a wheelchair upon discharge.

The Nurse Practitioner (NP) discharge summary dated 03/24/21 read in part, Resident #1 "is aware of recommendation to stay at facility for strengthening, however, he refuses. He is at high risk for hospital readmission due to inability to care for himself independently. He is insistent to leave and states he has 24 hour care from family for two weeks. He is aware of recommendation to continue 24 hour care once family member leaves and of safety concerns. He did transfer with minimal assistance with help of sliding board from bed to wheelchair and back during assessment. DME needed upon discharge: transfer bench, sliding board, bariatric wheelchair and hospital bed. Home health needed for physical and occupational therapy and caregiver assistance with Activities of Daily Living (ADL)."

A physician's order dated 03/24/21 read, "discharge home with 24-hour care provided by family 03/29/21. Home health orders: PT and OT evaluate and treatment, Nurse for disease/medication management, Aide for ADL/caregiver assist."

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The Occupational Therapy (OT) discharge summary dated 03/26/21 indicated Resident #1's therapy services ended due to exhaustion of insurance benefits and he would be discharging to live alone in a private residence. It was noted discharge home was not recommended because he was not able to complete transfers without assistance, displayed decreased strength and endurance for functional tasks and was unable to transfer to a 3-in-1 bedside commode (portable toilet).

The Physical Therapy (PT) discharge summary dated 03/26/21 indicated Resident #1's therapy services ended due to a change in payer source and he would be discharging home with support and assistance from others. Recommendations were: 24-hour caregiver assistance at home and home health services.

An entry dated 04/01/21 read in part, SW met with Resident #1 to review discharge paperwork. Resident #1 was informed home health services would begin on 04/03/21. Resident #1 will also receive personal care services through his insurance company. He will discharge from the facility with a wheelchair and a hospital bed will be delivered to his home on 04/07/21. He will be transported home by facility transport. Resident #1 signed discharge paperwork and expressed understanding.

The Transition and Discharge Plan (TDP) signed by Resident #1 on 04/01/21 included the name and contact numbers for home health and personal services agencies that would provide him with services. The TDP noted that prior to Resident #1's discharge, he was observed as

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needing "a great deal of help" with getting up and down, washing and bathing self, dressing, grooming, and preparing meals and "total help recommended" with him getting around.

The Emergency Department (ED) history and physical progress note dated 04/03/21 read in part, Resident #1 had several, recent hospitalizations for inability to care for himself and two recent rehab stays for inability to ambulate. Resident #1 was discharged from a SNF two days ago. He reports home health services arranged by the facility had not yet started and a hospital bed to be delivered to his home had not yet arrived. Resident #1 stated since discharging home two days ago, he spent the entire time in his wheelchair as he was not able to get out of it. He called Emergency Medical Services (EMS) to bring him to the hospital today with complaints of generalized weakness, shortness of breath and soreness of his buttocks due to remaining in his wheelchair. The physical exam revealed Resident #1 had an elevated blood pressure reading of 172/80, skin of the inguinal area (lower abdomen) and buttock was somewhat irritated with no clear pressure sores and smeared stool was noted on both legs. The ED history and physical also noted labs on 04/03/21 indicated acute kidney injury with a creatinine of 3.86 which was well above his baseline 1.0. and suspected hypovolemia (volume of blood plasma too low). The plan was to start intravenous fluids and hospitalize. He was stable for discharge on 04/07/21 and ultimately discharged to his home on 04/09/21.

During telephone interviews on 04/14/21 at 10:22 AM and 2:47 PM, Resident #1 reported he discharged home on 04/01/21 due to his

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insurance coverage ending and explained he could not afford to pay the facility to stay while also paying to maintain his home. Resident #1 verbalized he wanted to return home as he felt he would be able to care for himself; however, once home he was too weak and unable to transfer from his wheelchair to use the bedside commode. He added he was not provided with a sliding board to use and could not get to his bedroom or bathroom to retrieve his urinal because the wheelchair the facility provided was too wide to go through the bedroom and bathroom doors. He stated he was only able to access the kitchen and den while in his bariatric wheelchair and was able to get something to eat and drink. Resident #1 explained the facility gave him prescriptions upon his discharge but he did not have transportation to get the prescriptions filled so he took the medications he had left at home prior to going to the hospital and could not recall what they were. He confirmed the facility arranged his transportation home and the transport driver assisted him with getting his wheelchair through the kitchen door but did not enter his home. Resident #1 stated prior to his discharge, he informed the facility his family lived out of state and he had tried to arrange a 24-hour caregiver to stay with him but did not have anyone that could help him at home. Resident #1 stated the first day he was home, he called a neighbor to come assist him with cleaning up after using the bathroom in his wheelchair but didn't think to have the neighbor get his urinal from the bedroom for him. He recalled having pain from a sore area on his bottom and after remaining in his wheelchair, he contacted 911 on 04/03/21 to transport him back to the hospital.

During an interview on 04/14/21 at 3:25 PM,

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Nurse Aide (NA) #1 reported she was routinely assigned to provide Resident #1 with care during his stay at the facility. NA #1 recalled Resident #1 could perform a lot of ADL on his own; however, he was unable to transfer independently, did not want to attempt to transfer with assistance to use the bedside commode and instead, preferred to use a bedpan and urinal for toileting needs.

During an interview on 04/14/21 at 12:38 PM, the SW recalled Resident #1 "went back and forth" about whether to stay at the facility or go home once his insurance coverage ended. She added Resident #1 did not want to risk losing his home by using his income to pay to stay at the facility. The SW recalled having a conversation with the facility NP about Resident #1's discharge and the NP stated his discharge might be AMA because he was not safe to return home alone. The SW added the NP later spoke with Resident #1 about his discharge plans and Resident #1 told the NP he had arranged for a 24-hour caregiver to stay with him for two weeks when he discharged from the facility. The SW stated in preparation for Resident #1's discharge, she arranged home health services with the agency of his choice and ordered the DME recommended by therapy that consisted of a bariatric wheelchair, sliding board and hospital bed. She explained when she contacted the DME company to order the bariatric wheelchair and sliding board, they informed her Resident #1's insurance would not pay for a sliding board and they would have to order a wheelchair in his size which would take some time. She informed the Administrator about the situation with Resident #1's DME order and he approved for the facility to provide Resident #1 with a bariatric wheelchair to return home. She

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added the earliest a hospital bed could be delivered to his home was on 04/07/21 and when she spoke with Resident #1 he didn't want to stay at the facility until the bed could be delivered. The SW stated on the day of his discharge, she reviewed the discharge paperwork with Resident #1 and provided him with a copy that contained the contact numbers for the home health agency. The SW added she also provided Resident #1 with prescriptions for medications he needed to have filled along with the remaining medications he had left but could not recall what the medications were. The SW confirmed she was aware that prior to Resident #1's admission, he had a failed discharge attempt home from another Skilled Nursing Facility (SNF) and stated she felt it would be a safe discharge because he had a 24-hour caregiver arranged at home for two weeks.

During interviews on 04/14/21 at 11:50 AM and 2:30 PM, the Director of Rehab (DOR) explained a few days before a resident's anticipated discharge, she discussed with the SW therapy's recommendations related to the resident's discharge needs, such as DME and home health services, and the SW made the arrangements. The DOR stated when Resident #1 first admitted, he started out well with therapy but his progress wasn't consistent, he started to decline and needed more assistance with transfers. She explained one day Resident #1 could take a few steps or stand 1 to 3 minutes with assistance and then the next day he wouldn't be able to get up out of bed. The DOR spoke with Resident #1 and explained that from a therapy standpoint, they did not feel he was ready for discharge but he was insistent on returning home and didn't seem to understand that his level of function while at the

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facility was not the same as when he previously lived at home alone. She recalled the NP also had a conversation with Resident #1 about her concerns with him discharging home and the NP had informed the DOR that Resident #1 stated he would have a 24-hour caregiver in the home for two weeks when he discharged from the facility. After her conversation with the NP, the DOR stated she spoke with Resident #1 and he confirmed what the NP had reported. The DOR explained Resident #1 did well with minimal assistance when using a sliding board with transfers and with the aid of a caregiver in the home, she felt it would be a safe discharge.

During a follow-up telephone interview on 04/15/21 at 9:58 AM, the DOR verified she was aware that prior to his admission, Resident #1 was at another SNF, discharged home and readmitted to the hospital a day later. She added when Resident #1 talked about discharging home, she reminded him what happened before and that his level of function was much different now but he was adamant and kept stating he could do it. She did not recall being informed Resident #1's insurance would not pay for a sliding board or that he did not have one when he discharged home. She stated she was aware of the issue with ordering a bariatric wheelchair from the DME company and recalled the Administrator approved for Resident #1 to take one of the facility's wheelchairs when he returned home. The DOR confirmed a home assessment was not conducted to identify any potential barriers in Resident #1's home prior to his discharge from the facility on 04/01/21.

During a telephone interview on 04/14/21 at 12:32 PM, the NP stated Resident #1 had intact

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THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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 660	Continued From page 12	F 660		

cognition and was adamant about returning home. She recalled that prior to his admission Resident #1 had discharged home from another SNF and within a day had returned back to the hospital. The NP stated at one point she thought his discharge would be AMA and when she discussed her concerns with him, he reported a family member would be staying with him at the home for two weeks. The NP added he was able to use a sliding board for transfers with assistance and as long as he had help in the home, she felt it would be a safe discharge.

During a telephone interview on 04/14/21 at 2:14 PM, the Home Health Start of Care Nurse (HHSCN) confirmed a referral was received from the facility requesting services for Resident #1 with an anticipated discharge date of 04/01/21. The HHSCN stated she remembered Resident #1 from a prior referral when he was discharged home from another SNF the end of February 2021. She explained when she visited Resident #1 the day after his discharge in February 2021, he had not moved from his recliner, could not reach any water, food or clean himself, and was unable to even stand up by the recliner for a skin assessment. The HHSCN added she sent him back to the hospital where he stayed until he was discharged to the current SNF. The HHSCN stated when she received the new referral for home health services, she contacted Resident #1 on 04/01/21 at the facility before he discharged and he had expressed to her he didn't understand why the facility was discharging him and confirmed he did not have any support in the home. After speaking to Resident #1, the HHSCN stated she did not feel it would be a safe discharge home for him as he was unable to care for himself or walk, had no one to help him in the

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F 660	Continued From page 13	F 660		

home and no means to obtain prescriptions. The HHSCN discussed her concerns with the Home Health Client Service Manager (HHCSM) who agreed Resident #1 was not appropriate for their services at that time.

During a telephone interview on 04/14/21 at 2:39 PM, the HHCSM stated after receiving report from the HHSCN, they decided Resident #1 was not appropriate for home health services since he was not returning home with 24-hour care. The HHCSM stated she contacted the facility SW and left a voicemail explaining why they would not be providing services. The HHCSM added she provided names and contact numbers for the SW to call with any questions but they did not hear back from her.

During a second interview on 04/14/21 at 2:20 PM, the SW stated when Resident #1 was discharged, she understood the home health agency would start services within 48 hours of him returning home and did not recall receiving a voice mail message from the home health agency informing her they would not be able to pick up Resident #1 for services.

During a telephone interview on 04/21/21 at 3:21 PM, the Administrator explained he did not have a direct role in the discharge planning process and relied on the team to ensure discharge plans were in place when residents discharged from the facility. The Administrator could not recall if it was Resident #1 or staff that had mentioned Resident #1 had 24-hour assistance arranged when he discharged home. He added staff did report Resident #1 would not tell them the name of the caregiver he had arranged, just stated it was a family member. The Administrator stated he was

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F 660	Continued From page 14 not aware Resident #1 did not have a sliding board upon his discharge from the facility but did give approval for Resident #1 to take one of the facility's bariatric wheelchairs to use at home. The Administrator added neither he nor facility staff had any knowledge of receiving notification from the Home Health Agency that they would not be providing Resident #1 with home health services upon his discharge.	F 660		