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	345403	A. BUILDING ______ B. WING ______	C 08/12/2021

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CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 08/04/21 through 08/12/21. One of the three complaint allegations was substantiated resulting in deficiency. Immediate Jeopardy was identified at: CFR 483.15 at tag F624 at a scope and severity (J) Immediate Jeopardy began on 08/02/21 and was removed on 08/05/21.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		8/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/26/2021

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

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F 585	Continued From page 1 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 585		

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F 585	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident, responsible party (RP) and staff interviews and record review, the facility failed to complete a grievance form and follow up with the resident and the RP regarding missing clothes reported during a resident council (RC) meeting on 7/21/21. This was for 1 (Resident #6) of 3 residents reviewed for grievances. The findings included:	F 585	1. On 8/4 resident #6 was interviewed by facility administrator and a grievance form was completed regarding the resident's missing clothing to include two missing pair of jeans and five shirts. The facility administrator reviewed the finding of the grievances dated 7/21/21 regarding missing clothing. The facility reimbursed the resident $100 as resolution to the	

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F 585	Continued From page 3 Resident #6 was admitted on 12/16/19 with a diagnosis of Atrial Fibrillation. Her quarterly Minimum Data Set dated 7/19/21 indicated Resident #6 was cognitively intact and she exhibited no behaviors. A review of the Resident Council Minutes dated 7/21/21 was completed. Resident #6 voiced she was still missing some of her clothes. The HK Supervisor was notified on 7/21/21. The minutes read the issue was partially resolved but further steps were needed. Review of a Missing Items form dated 7/21/21 and completed by the HK Supervisor read as follows: *Resident #6 was missing 2 pairs of jeans and 5 shirts *A specific laundry staff member always washed Resident #6's clothes *Resident #6's clothes have been missing since the COVID-19 outbreak (January 2021) *Resident #6's clothes were labeled *The laundry area, residents rooms were checked and a notice was posted in the laundry room *Item located: no *Family notified by: yes *If item was not located, please complete a grievance form. Review of the facility grievance policy dated last revised 1/21/20 read as follows: *An employee receiving a complaint/grievance from a resident, family member and/or visitor shall initiate a complaint/grievance form. *The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days.	F 585	grievance. During the follow up discussion the resident expressed that she was satisfied with the resolution. A copy of the resolution was given to Resident #6 on 8/5/21 by the facility administrator. 2 The facility administrator will review the resident council minutes for the previous quarter to ensure that all grievances were placed on a grievance form and that each had written/oral resolution to the grievances on 8/26/21. Members of the facility department head team to include activity director and the business development coordinator will be assigned to interview residents that are identified as interviewable to ensure that grievances or concerns have documented on a grievance form and each have a timely resolution not to exceed fourteen days and offered written resolution of the grievance or concern by 8/27/21. 3. The Regional Director of Clinical Services will provide education to the facility administrator and director of nursing regarding the facility grievance policy by 8/24/21. Once the facility administrator/designee receive the re-education the administrator will then provide education to the facility staff regarding the grievance policy. Any facility staff that does not receive the re-education regarding the facility grievance policy prior to 8/27/21 with receive the re-eduation prior to working the next scheduled shift.	

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*The individual voicing the grievance shall receive follow up communication with the grievance decision. A copy of the written grievance decision including a summary statement, steps taken to investigate the grievance, summary of the pertinent findings or conclusions, a statement as to whether the grievance was confirmed or not confirmed, and corrective actions taken and date the decision was issued will be provided to the resident.

Resident #6 was interviewed on 8/4/21 at 2:50 PM. She recalled mentioning her lost clothes in the July RC meeting. Resident #6 stated 7/21/21 was not the first time she had brought up the missing clothes. She stated she and her RP had asked about her missing clothes on other occasions and nobody at the facility provided any follow up or response. She stated that was why she reported it again on 7/21/21 in the RC meeting. She further stated nobody had mentioned anything about a grievance.

An interview was conducted on 8/4/21 at 3:50 PM with the HK Supervisor. She stated thought it was about a week ago, it was reported again during a RC meeting that Resident #6 was still missing her clothes. The HK Supervisor stated she did not realize how long it had been since Resident #6 reported her missing items on 7/21/21. She stated on 7/21/21 she completed a Missing Items form and added Resident #6's missing items to the missing items log in the laundry room. She recalled speaking to Resident #6 and she said told her that her items had been missing since first covid outbreak (January 2021). The HK Supervisor stated with all the rooms changes, it was likely items got mixed up and put in someone else's closet. She stated she did not complete a

F 585

4. The facility administrator will complete a quality monitoring audit of four sampled residents to ensure that any concerns/grievances have been written on a grievance form and appropriate resolution is documented and a copy of the resolution has been offered to the person with the concern weekly X 4 weeks and bi-monthly X 1 month and monthly x 1. The facility administrator will report the findings of the Quality Monitoring Audits to the Quality Assessment Improvement Committee monthly X 3 months. The results of the findings will be reviewed by the committee to determine if further action is needed.

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F 585	Continued From page 5	F 585		

room sweep after the 7/21/21 RC meeting to see if Resident #6's missing clothes were inside another resident's closet. The HK Supervisor stated she called the family and told them the facility could not find the missing items. She was unable to recall when or who she spoke with at that time and she did not follow up with Resident #6. She stated she did not complete a grievance at that time when the items weren't found because the Administrator completed the grievance form if missing items were not found.

A telephone call was made to Resident #6's RP on 8/4/21 at 4:00 PM. She stated Resident #6's items were clearly labeled with her name. She stated she had spoken to staff and the HK Supervisor in the past about her mother's missing clothes. She stated the items went missing sometime around the first of the year and the only response offered was the facility could not find them. She also stated she requested the same person wash Resident #6's clothes to avoid losing anymore items. The RP stated nobody ever mentioned anything about a grievance form or investigation.

A second interview was conducted on 8/5/21 at 4:20 PM with the HK Supervisor. She stated she called Resident #6's RP yesterday (8/4/21) and told her they would continue to look for her missing items and would follow up with her again. She further stated she went to talk to Resident #6 about her missing clothes yesterday and relayed the same information. The HK Supervisor stated she was also to follow up with the Administrator after she completed looking for Resident #6's missing items.

An interview was conducted on 8/5/21 at 11:50

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F 585	Continued From page 6 AM with the Administrator. She stated if missing items were not located, a grievance should have been completed and given it to the department involved. She also stated the facility was in the process of completing a grievance along with an investigation to attempt to find Resident #6's missing clothes. The Administrator offered no explanation as to why a grievance form was not completed or why no follow up with the RP or Resident #6 was completed until 8/4/21.	F 585		
F 624 SS=J	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 by: Based on record review and interviews with family, fireman, home healthcare nurse, and staff, the facility failed to assess the resident's home environment to identify and evaluate barriers of the discharge location and failed to verify the assessed level of caregiver support was in place for the resident's safe discharge home. The facility also failed to include monitoring for exhaustion of benefits and notification to the resident and/or involved family of benefit exhaustion in their discharge planning process. This was for 1 of 3 residents (Resident #1) reviewed for discharge. Immediate Jeopardy began on 8/2/21 when	F 624	1. Resident #1 was discharged from the facility on 8/2/21 to home with physician orders for home health services. The resident arrived at home with one caregiver present. The family was unable to get the resident into the house and called the fire department for assistance. On 8/3/21 it was identified that the resident's caregiver, the daughter, was unable to provide adequate assistance with incontinence care and mobility. The facility was contacted by the daughter at approximately 8:45 am that there was an issue with her dad staying in the home. The facility immediately offered to return	8/27/21

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Resident #1 was discharged from the facility and transported to his home in the community via a private transportation ambulette (a specially equipped van for non-emergent transportation). Upon arrival home the transport driver assisted Resident #1, who was in a bariatric wheelchair (a wheelchair for larger adults weighing 300 pounds or more), off of the vehicle and onto the sidewalk in front of his home. The home had 2 stairs leading to the front door and no wheelchair ramp. Family Members #1 and #3 were present at the home, but they were unable to get Resident #1 into the home on their own due to his size and his need for extensive assistance with transfers. Family Member #3 contacted their local Volunteer Fire Department as well as additional family members to assist with getting Resident #1 from the sidewalk into the home. The family built a makeshift wheelchair ramp using wood 2 by 6s and concrete blocks in order to get Resident #1 up the stairs. It took approximately 2 hours and 6 people to get Resident #1 into the home. The Immediate Jeopardy was removed on 8/5/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put into place related to the discharge planning process are effective and to complete staff training.

The findings included:

Resident #1 was admitted to the facility on 5/25/21 with diagnoses that included fracture of

F 624

the resident to the facility and offered the assistance of the business office in that effort. The facility called the daughter back at approximately 9:05 and left a message with the administrator's personal cell phone number in case the daughter called during morning meeting. The facility was additionally notified by the state agency at 9:30 that there was a concern. The facility, again, reached out to the family and was informed that they were having a family meeting and were not sure that they wanted to return to the facility. After several additional calls between the family and the facility the resident was re-admitted to the facility on 8/3/21.

2. Residents being discharged have the potential to be affected by the alleged deficient practice. The facility Social Worker and Regional Director of Clinical Services reviewed every resident who has discharged home in the last 30 days to ensure that a safe discharge occurred as evidenced by Quality Improvement Data Collection Form. This review included confirmation that a safe location/placement, mobility/accessibility needs can be met, medications or prescriptions provided, and all other home care needs such as appointments, home health and arrangement for medical equipment were met by completing the checklist for discharge planning.

The Social Worker and the Regional Director of Clinical Services also reviewed the residents that are pending discharge to home in the next 7 days as evidenced by the discharge planning checklist. This review included a safe

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fibula (the outer of two bones of the lower leg), metabolic encephalopathy, Diabetes Mellitus (DM), atrial fibrillation, kidney failure, cognitive communication deficit, and muscle weakness.

Resident #1's care plan, initiated on 5/25/21, included the focus area of his wish to return home. The goal was for Resident #1 to verbalize/communicate an understanding of the discharge plan and describe the desired outcome by the target date of 8/23/21. The interventions, all initiated on 5/25/21 included:
- Encourage Resident #1 to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, and distress.
- Establish a pre-discharge plan with Resident #1 and his family upon admission in the care navigation meeting and evaluate progress and revise plan as needed
- Evaluate/record Resident #1's abilities and strengths, with resident's representative/caregivers/Interdisciplinary Team (IDT). Determine gaps in abilities which would affect discharge.
- Make arrangements with required community resources to support independence post-discharge.

The admission Minimum Data Set (MDS) assessment dated 5/31/21 indicated Resident #1's cognition was intact. He had no behaviors and no rejection of care. He required the extensive assistance of 2 or more for bed mobility, dressing, toileting, and personal hygiene. Resident #1 was dependent on 2 or more for transfers and bathing. Locomotion on/off unit had occurred only once or twice with 1 assist. He had no functional impairment with range of motion

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location/placement, mobility/accessibility needs can be met, medications or prescriptions provided and all other home care needs such as appointments, home health and arrangement for medical equipment.
The interdisciplinary team, including the social worker, director of rehab and the MDS nurses, will evaluate each resident to determine in home evaluations is needed by rehab prior to discharge using a home assessment questionnaire. It will be completed within 7 days of planned discharge date, by the appropriate therapy modality, ie. physical therapy and/or occupational therapy. Residents will be educated by the nursing staff member and social services member on the healthcare consequences and safety concerns per the checklist.
3. The executive director, director of nursing, MDS nurses, director of rehab and social work were educated by the regional director of clinical services on discharge policies including discharge planning as evidenced by education in-service sign in sheet and policy and procedure for interdisciplinary discharge planning. Residents with planned discharges will be reviewed in morning meeting when a discharge date is confirmed and the social worker will send notification to departments to coordinate discharge when a date is confirmed to verify discharge plan is appropriate for resident needs as evidenced by morning report form. On admission the resident's discharge goal and estimated length of stay will be established. The goals will be

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and he utilized a wheelchair. Resident #1 had an indwelling catheter, he was always incontinent of bowel, and he had 3 stage 2 pressure ulcers. He had a fall in the last month prior to admission and a fall with fracture in the last 6 months prior to admission. Resident #1 received antidepressant medication and anticoagulant medication on 7 of 7 days. He was receiving Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST).

A nursing note dated 6/3/21 indicated Resident #1's indwelling urinary catheter was discontinued as ordered by the physician.

Resident #1's care plan was updated on 6/4/21 with a focus area for an Activities of Daily Living (ADL) self-care performance deficit related to impaired balance, limited mobility, and status post fracture left fibula. The goal was for Resident #1 to improve his current level of function through the target date of 8/23/21. The interventions (all initiated on 6/4/21) indicated he was totally dependent on 1 to 2 staff for bathing/showering and required the extensive assistance of 2 staff for transfers. Resident #1 required the extensive assistance of 1 to 2 staff for bed mobility and dressing and the extensive assistance of 1 staff for toileting and personal hygiene.

A hard copy typed document completed by the Social Worker (SW) revealed the following information:
- On 7/27/21 the SW met with Resident #1 to inform him of his upcoming 100th day of his Medicare benefit. The SW wrote that Resident #1 had expressed his desire to stay at the facility, but felt he had not wanted to apply for Medicaid and could not afford the private rate. The SW

F 624

based on clinical findings, availability of community and family resources and resident and family goals. The discharge planning record will be completed within seven days after admission by the Interdisciplinary Team (IDT), which consists of social work, nursing, dietary and rehab.
The resident's estimated length of stay and discharge goals will be reviewed/revised at the resident's first and subsequent team conference.
The IDT will meet weekly to review all residents with discharge plans to return home and how close residents are in exhaustion of their benefits. The IDT will review and adjust, as appropriate, during weekly discharge planning meeting.
Once the date of discharge is determined the social worker will make necessary the referrals to outside agencies to include home health, medical equipment and any follow up appointment. The IDT will also review with rehab if home evaluation is appropriate.
The IDT will initiate the discharge planning checklist the week prior to the discharge during the weekly discharge planning meeting.
Residents who will discharge home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs.
At the time of discharge, a discharge summary and home discharge instructions will be provided to the resident and/or the resident's caregiver.
Within 24 to 48 hours after discharge to

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F 624	Continued From page 10 told him that she would assist him with the discharge process and would make referrals for home healthcare nursing, PT, OT, and Nursing Assistant (NA). Resident #1 stated that he had all the equipment he needed at home. - On 7/28/21 the SW met with Resident #1 to discuss discharge planning. His spouse was noted to be listening in by way of speaker phone. The SW explained that his last covered day at the facility was 8/1/21 so he had to be discharged on 8/2/21. They discussed home healthcare services and equipment that was needed. Resident #1 indicated he had all of the necessary equipment at his home already and his spouse requested a bariatric commode (designed for the toileting, showering, and hygiene routines of larger adults weighing 300 pounds or more) for the resident. Physician's orders for Resident #1 dated 7/29/21 indicated: 1) Home healthcare referral for nursing, NA, PT, and OT; 2) Bedside bariatric commode for a weight of 412 pounds. A hard copy typed document completed by the SW revealed the following information: - On 7/30/21 the SW met with Resident #1 to sign his Notice of Medicare Non-Coverage (NOMNC) and reiterated that his last covered day would be 8/1/21. Resident #1 asked questions about how his 100 days were already exhausted and the SW explained to him the days he spent in another facility prior to coming to this facility counted in his total days. The SW wrote that she talked with Resident #1 about getting ready for discharge. His family was to come to the facility over the weekend (7/31/21 - 8/1/21) to pick up the majority of his belongings and to bring in his personal wheelchair. The SW indicated that she explained	F 624	home a follow up call will be made by the Social Worker to ascertain that community services/referrals are indeed being provided according to the discharge plan. 4. The facility executive director will complete quality monitoring audit of 5 sampled residents that are identified as discharged from facility to home in the last 30 days to ensure that the discharge process was followed and appropriate weekly x four weeks, bi-monthly x 1 one month and monthly x 1 month. The facility executive director will report the results of the Quality Monitoring audit to the QAPI committee monthly x 3 months. The committee will review the results to determine if further action is needed.	

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F 624	Continued From page 11 the transportation cost of an ambulette and he stated that he would not pay for that and he would go by car. SW stated to Resident #1 that he was not able to transfer independently and asked Resident #1 how was he going to get out of the car when he arrived at his home. He stated that he would do it with Family Member #3 and a family friend. Resident #1 also spoke about the stairs that he had at the house and he reported that they had no wheelchair ramp yet. The SW gave him information on a ramp that could be purchased online and delivered to his home. - On 7/30/21 the SW, Director of Therapy (DOT), and the Business Office Manager (BOM) had a phone conference with Resident #1's Family Member #1 who was expressing great concern about his returning home. The SW wrote that they (SW and DOT) also expressed that they felt this discharge was premature. The SW noted that she expressed concerns about the stairs with no wheelchair ramp and the car ride. The DOT spoke about Resident #1's lack of progress in therapy and what his short comings and safety issues were. Family member #1 indicated she would talk with her family and call back. - On 7/30/21 the SW spoke with Family Member #1 after the phone conference and she decided that Resident #1 would be transported by ambulette. She also told the SW that a community organization was going to build a wheelchair ramp at the home on the morning of 8/2/21 so his discharge time would be set for after 3:00 PM. The SW completed referrals for home healthcare and medical equipment (bariatric commode). A DOT hard copy note dated 7/30/21 indicated she attended a conference call meeting for Resident #1 with the SW present and Family	F 624		

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Member #1 on the phone. She wrote that during the conversation they discussed concerns for Resident #1 returning home as he would require extensive assistance from the family. Family Member #1 was informed he required maximum assistance to perform a sit to stand from any surface and that once he was standing he was able to walk short distances. Family Member #1 expressed concerns regarding the living environment, in particular the doorways that may not accommodate his bariatric wheelchair. The DOT indicated she explained to the family that it may not be feasible to have Resident #1 walk through doorways as he needed extensive assistance just to stand up from a chair. The DOT wrote, "[Family Member #1] also stated she didn't think [Resident #1] was ready to come home yet and we agreed with her". Family Member #1 was informed that Resident #1 could be treated at the facility for therapy after his Medicare benefit was exhausted. Family Member #1 was also informed that they (the SW and DOT) had not believed it was reasonable to attempt to transport Resident #1 home by personal vehicle for his safety and theirs.

A SW note in the Electronic Medical Record (EMR) dated 7/30/21 (entered as a late entry note on 8/3/21) indicated the SW and DOT had a phone conference with Resident #1's Family Member #1 to discuss his upcoming discharge on 8/2/21. Family Member #1 expressed her concerns about his not being ready to come home. SW wrote that she discussed with Resident #1 and his spouse their options of a Medicaid application or private pay to remain at the facility and neither option worked for them. The SW indicated she told Family Member #1 that she was very concerned that Resident #1

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wanted to go home in a car as he was not able to transfer and would really struggle getting in the house. The SW further wrote that Resident #1 informed her he had no wheelchair ramp at his home to get up the 2 stairs to his front door. Family Member #1 informed the SW that a community organization was going to build the ramp on 8/2/21 so the SW pushed his discharge to 3:00 PM. Family Member #1 reported that she was able to convince Resident #1 and his spouse to let the SW arrange for an ambulette to take him home rather than being transported by car. The SW wrote, "[DOT] told [Family Member #1] she felt this was an unsafe discharge and we felt [Resident #1's spouse] would not be able to provide him with the assistance he needs. Resident told SW he felt sure they would handle it."

An OT discharge summary for services from 5/25/21 through 7/30/21 indicated Resident #1 required substantial help with bathing, dressing, and toileting and moderate help with transfers.

A PT discharge summary for services from 5/26/21 through 7/31/21 indicated Resident #1 needed assistance for bed mobility, transfers, and ambulation.

The Discharge Plan and Instructions form dated 8/2/21 indicated Resident #1 was to be discharged home to a private house with his spouse due to his 100 days of Medicare being exhausted and declining to pay privately. He was noted to be admitted to the facility after being hospitalized from a previous facility for altered mental status. He had suffered a fractured fibula weeks earlier. Resident #1 was admitted for rehabilitation, strengthening, and mobility. His

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insurance days were up so he was being discharged to his home. His functional mobility/self-care skills revealed the following questions and answers:
- You can get up and down from a seated position: With a great deal of help
- You can go up and downstairs with handrails: Not recommended
- You can move around: With a little help
- You can wash and bathe: With a great deal of help
- You can dress: With a great deal of help
- You can prepare your own meals: Total help is recommended
- Toilet use: Total help is recommended

The social service discharge summary on his form indicated that the SW made referrals for home healthcare nursing, PT, OT, and NA services and ordered a bariatric commode. SW gave Resident #1 information on a wheelchair ramp he could order from an online site if he was not able to have a ramp built. The SW arranged for an ambulette. The discharge body audit indicated Resident #1 had a blister to his left thigh and buttocks, but had no open wounds. The nursing discharge summary on this form indicated that Resident #1 left the facility around 4:00 PM via ambulette. His discharge instructions/information were given to him and he voiced understanding of the instructions. He took all belongings, medications, and prescriptions.

A home healthcare discharge summary completed by the Home Healthcare Nurse dated 8/3/21 revealed the following:
"[Resident #1] was not accepted for care due to safety concerns. [Resident] is morbidly obese, weighing in excess of 400 [pounds]. According to [Resident #1] and family [he] is unable to get up

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out of the recliner without aide of at least 3 people, and if an emergency takes place requiring [Resident #1] to exit the [home] he would be unable to do so safely. [Resident #1's] needs are also unable to be met [due to] the amount of assistance he needs and family unable to provide. [Adult Protective Services] referral was made ...".

A SW note dated 8/4/21 indicated Resident #1's discharge home was very difficult for him and his family. Volunteer firemen needed to get him in the home. His family felt that they couldn't meet his needs at home and had him readmitted on 8/3/21. The Business Office staff spoke with them about applying for Medicaid and the facility would assist them with the process. The SW wrote that the family stated they were not given any other options besides discharge home or private pay but that she spoke with Resident #1 and his spouse on the speaker phone about the option of Medicaid.

A phone interview was conducted on 8/4/21 at 7:10 PM with Resident #1's Family Member #1. She stated that on 7/28/21 Resident #1's spouse phoned her to let her know that she and Resident #1 spoke with the SW and they were informed his last Medicare covered day at the facility was 8/1/21 due to him exhausting his 100 day benefit. The spouse reported that the SW said he would either have to be discharged home or they would need to pay privately. Family Member #1 stated that this was the first time she heard any mention of his discharge and she was unable to understand why the facility wouldn't have let them know that his 100 days was approaching rather than waiting until he had less than a week out from his last covered day (8/1/21). Family

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F 624	Continued From page 16 Member #1 stated that the facility staff had not informed Resident #1 or any of his other involved family members (Family Members #2 and #3) that they could complete a Medicaid application and Resident #1 could stay at the facility while waiting for the Medicaid application to be approved. She revealed that she spoke with the SW and DOT by phone on 7/30/21 and both of these staff expressed concerns with him returning home. She explained that they spoke of his need for extensive assistance with his ADL care and the need for maximum assistance for transfers. Family Member #1 reported that she expressed concerns about the home environment to the SW and DOT. She indicated that Resident #1's home had 2 stairs going into the house and the doorways were all very narrow and would most likely not accommodate his bariatric wheelchair. She explained that when he lived at home previously he was able to ambulate with the use of a cane or walker, but he was no longer able to do so. Family Member #1 revealed she asked the SW if they had any options other than private pay or discharge home and no other options were provided. She added that Family Member #2 also spoke with the SW on 7/30/21 and no mention of a Medicaid application was made to her either. She stated that she felt like they said, "time is up and he has to get out or pay" so she proceeded with the plans for him to discharge home with his spouse as she thought she had no other choice. She added that Resident #1's spouse was elderly and she was unable to provide the assistance he needed for ADL care. Family Member #1 revealed that there was no home assessment completed prior to Resident #1's discharge from the facility. This phone interview with Family Member #1	F 624		

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F 624	Continued From page 17 continued (8/4/21 at 7:10 PM). She stated that Family Member #2 spoke with the SW on 7/30/21 about arranging the transportation home on the discharge date via an ambulette. She indicated that the SW scheduled the ambulette transfer. Family Member #1 reported that she got in touch with the local Department of Aging and they reported that they would install a wheelchair ramp on 8/2/21 for Resident #1 to be able to get into his home. She stated that at the time of discharge home on 8/2/21 the ramp had not been completed as scheduled so it was not installed at the time he arrived home. She was asked if she notified the facility that the ramp was not completed as scheduled and she stated that she had not. She explained that from her communication with the facility staff that she believed there was no other option than for him to be discharged on 8/2/21 so she thought the notification wouldn't have changed anything with his discharge date. Family Member #1 reported that she and Family Member #3 were at Resident #1's home when he was dropped off by the ambulette company. She stated that the ambulette driver got Resident #1 out of the vehicle and onto the sidewalk, but had not assisted them with getting Resident #1 inside of the house. Family Member #1 revealed that the family built a makeshift wheelchair ramp out of wood 2 by 6s and concrete blocks so they could get his wheelchair up the stairs that led to the front door of the house. She reported that she and Family Member #3 were unable to push Resident #1 up the ramp by themselves so they had to call in assistance from other family members and the volunteer fire department. She further revealed that once up this ramp they realized that his bariatric wheelchair would not fit through the front door as it was too wide for the	F 624		

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F 624	Continued From page 18 narrow doorway. She indicated that about 2 hours after Resident #1's arrival home and with the assistance of 6 people they were able to transfer Resident #1 into his spouse's wheelchair, which had a smaller frame, and they were then able to get him inside the house and transferred him to his electric lift recliner. She indicated that during that time period (2 hours) Resident #1 had a bladder movement and he had to remain in his wet brief. She stated that once Resident #1 was in this electric lift recliner he remained there for the rest of the day and overnight as he was not even able to transfer out of the electric lift wheelchair without maximum assistance of multiple people. Family Member #1 stated that she stayed at Resident #1's home with he and his spouse until around 11:00 PM when she returned to her own house. She indicated that during that time she was able to pull Resident #1's wet brief off of him and replace it with a clean one by sliding it under him. Family Member #1 indicated that she returned to Resident #1's house the following morning when home healthcare was scheduled for their initial visit. She stated that during the initial assessment by the Home Healthcare Nurse, Resident #1 was asked if he could get up and out of the house if there was an emergency and he reported that he would not have been able to do so. The Home Healthcare Nurse stated that they were unable to provide services to Resident #1 due to liability reasons as he was not able to escape in an emergency. Family Member #1 revealed that the Home Healthcare Nurse further stated that he was going to have to notify Adult Protective Services (APS) to file a report for Resident #1 residing in an unsafe environment. Family Member #1 stated that she and Resident #1's spouse were very overwhelmed and she reached out to the facility	F 624		

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and spoke with the Administrator by phone on 8/3/21. She reported that the Administrator said she would talk to the Business Office and see if they could assist with a Medicaid application. Family Member #1 stated that this was the first time anyone had mentioned a Medicaid application to her. She indicated she was agreeable to completing a Medicaid application for Resident #1. She further indicated that during the morning of 8/3/21 she and Family Member #3 phoned the State Agency seeking assistance and the State Agency spoke with the facility Administrator. Family Member #1 revealed that the Administrator informed her by phone that Resident #1 could be readmitted to the facility that day (8/3/21). She reported he was readmitted to the facility in the early evening on 8/3/21. She stated that although their problem was resolved by Resident #1 being readmitted, the discharge planning was non-existent and he was sent home to an environment where his care needs could not be met. She indicated that this was very scary and she feared that if it happened to someone else who had no family support that it could have very dangerous results.

During a phone interview with Resident #1 on 8/4/21 at 3:30 PM he stated that 7/27/21 was the first time he met with the SW to discuss discharge planning. He revealed he had no idea his Medicare benefit days were almost up at that time. He stated that the SW had not mentioned anything about applying for Medicaid. He reported he was told that he would have to discharge home on 8/2/21 or pay privately. Resident #1 stated that he shared this information with his spouse and his spouse informed Family Member #1. The events that occurred on his day of discharge (8/2/21) were reviewed with

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Resident #1. He confirmed Family Member #1's interview that indicated the family had to build a makeshift ramp and that it took 2 hours and 6 people to get him into the home and into his electric lift reclining chair where he remained until the following day.

A phone interview was conducted with Family Member #3 on 8/5/21 at 1:49 PM. He verified Resident #1 and Family Member #1's interviews stating that it took 6 people and approximately 2 hours to get Resident #1 up the makeshift ramp, into the house, and into his electric recliner. He further stated that he thought the makeshift ramp was dangerous to use, but that they had no other way to get Resident #1 up the stairs to the house.

A phone interview was conducted with Fireman #1 on 8/5/21 at 4:25 PM. He confirmed that he provided assistance with getting Resident #1 into his home after being discharged from the facility on 8/2/21. He indicated that Resident #1 appeared to be very weak and he was unable to actually support any of his own bodyweight when transferring him from the wheelchair to his electric reclining chair. He stated that this made it very difficult to transfer him and that it required 6 people to complete the transfer. Fireman #1 added that the makeshift ramp that was used to get Resident #1 up the front stairs to the house had not appeared very safe or sturdy.

A phone interview was conducted with the Home Healthcare Nurse on 8/5/22 at 4:22 PM. He stated that when he arrived at Resident #1's home on 8/3/21 there were building materials for a ramp outside of the home, but no ramp was in place. He indicated when he entered the home Resident #1 was seated in a recliner and he said

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that he had not been out of the recliner since he got home on 8/2/21. His spouse and Family Member #1 were present. Resident #1 and Family Member #1 explained that it took 6 people, to include family and firemen, to get him into the house and into the recliner. He indicated that Resident #1's spouse was elderly and about 100 pounds so she was not able to provide him with assistance. When Resident #1 was asked if he would be able to get out of the house if there was an emergency he indicated he would not have been able to do so. The Home Healthcare Nurse revealed that because of that safety concern, they were unable to admit him to home healthcare services. He further revealed that he notified APS due to the unsafe home environment for Resident #1. He indicated it was clear that Resident #1's ADL care needs were unable to be met by the family.

During a phone interview with Family Member #2 on 8/4/21 at 2:37 PM she stated that on 7/30/21 she spoke with the SW regarding transportation options for Resident #1's discharge from the facility. She revealed that during this phone call she asked if there were any options other than private pay or discharge and she was informed that these were the only options.

During an interview with the DOT on 8/4/21 at 3:08 PM she revealed that in her opinion Resident #1 was not ready to discharge on 8/2/21 as he could have benefited with a continuance of therapy to improve his ADL ability. She indicated that the SW was aware that she thought Resident #1 was not ready for discharge. She explained that at the time of his discharge on 8/2/21 he required maximum assistance for transfers and extensive assistance for most ADLs. She further

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explained that he was able to ambulate short distances with a rolling walker, but that this required maximum assistance to transfer him from a seated to standing position in order to get up to the rolling walker. The DOT revealed that the therapy department had not completed a home assessment for Resident #1 as they had ceased doing these since COVID-19 began. She stated that in place of an onsite home assessment she asked some general questions about the home during a conference call with one of the family members (Family Member #1) on 7/30/21. She stated that the family spoke about the stairs to the front entrance and the narrow doorways in the home. She stated that from her understanding a wheelchair ramp was going to be installed at the front of the house and that his family was going to be available to provide assistance with his ADL needs. She revealed she had not known that the ramp was not installed at the time of his discharge and she had not verified that the family was going to be available to provide the amount of assistance Resident #1 required to meet his care needs.

An interview was conducted with the SW on 8/4/21 at 4:02 PM. She stated that she began working at the facility about 5 weeks ago. She indicated she was not very familiar with Resident #1 until he was discussed in the morning clinical meeting on 7/26/21. She revealed that during that meeting she first learned that Resident #1's Medicare coverage benefits would be exhausted on 8/1/21. She further revealed that 7/27/21 was the first time that Resident #1 was informed of the upcoming exhaustion. She explained that on 7/27/21 she spoke with Resident #1 in his room and let him know that his last Medicare covered day in the facility would be 8/1/21. She indicated

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F 624	Continued From page 23 that Resident #1 was surprised and had not known this benefit exhaustion was coming up so soon. The SW stated that she told Resident #1 that he could stay at the facility and pay privately, apply for Medicaid, or discharge home. She reported that he said he had not wanted to apply for Medicaid and that he would talk with his spouse. She stated that on 7/28/21 she met with Resident #1 again and during this meeting his spouse was on the phone via speaker. They indicated that they were not going to pay privately so she began to discuss discharge planning for him to go back to his private home where he resided with his spouse. The SW stated that was when she informed Resident #1 and his spouse she would made a referral for home healthcare services and order any medical equipment he required. She indicated she had not brought Medicaid up again as she assumed that Resident #1 had discussed this option with his spouse and family members and that this was not an interest to them. She revealed she had never discussed the option of a Medicaid application with Resident #1's family members who were involved with his care (Family Members #1, #2, and #3). The SW spoke about the phone conference she had with the DOT and Family Member #1 on 7/30/21. She stated that this conference included a discussion about his transportation home. She explained that Resident #1 wanted to travel by car, but she and the DOT felt that this was not feasible due to his inability to transfer out of the car once at home. She further explained that it seemed as if Resident #1 and the family had not realized what his functional limitations were. She stated that it was obvious that Resident #1 overestimated his ability to do things on his own which was why he thought he could be transported home by car.	F 624		

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F 624	Continued From page 24 This interview with the SW continued (8/4/21 at 4:02 PM). She was asked if a home assessment was completed prior to Resident #1's discharge and she stated that because she was new to the facility she was not sure what the normal protocol was for a home assessment, but that she believed this would have been the therapy department's responsibility. She indicated she thought therapy was not completing home assessments in person due to COVID-19 protocols. She was asked what the plan was for Resident #1's care needs to be met at home where he resided with his elderly spouse and no other live in family members. SW #1 stated that Resident #1 made it seem like his family would be there to help him with everything and he said they would make it work. She acknowledged that Resident #1 overestimated his own functional abilities and that he may not have realized how much assistance he actually needed. The SW was asked if she verified the timeframes that his family would be with him in the home to provide care and she revealed that she had not. She was asked if his spouse would have been able to assist him with his care needs and she indicated that she had never seen Resident #1's spouse in person to assess her abilities, but due to the fact that she was also elderly and that he required maximum assistance and was a large man that it was doubtful. She indicated that she asked Resident #1 how he was going to get into the house when he got home and he stated that 2 of his family members would be there to help him. The SW revealed that at the time of discharge on 8/2/21 she had not verified the wheelchair ramp was installed. She explained that she assumed this had been completed as scheduled. She revealed that it was not until today (8/4/21) that she learned that the ramp had not been installed	F 624		

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F 624	Continued From page 25 at the time of discharge and that it took 6 people to assist him to get into the home. She further revealed that she also learned today that home healthcare refused to provide services due to an unsafe living environment and that they had notified APS. The SW stated that this was an unfortunate situation as she was not familiar with the facility's normal discharge planning process due to being so new to the facility so she had completed no discharge planning with Resident #1 prior to 7/27/21. She further stated that she had not verified the family assistance that Resident #1 would have at home as she took him for his word that his family would be there to assist him and that they would make it work. She revealed that in hindsight, she absolutely would have done things differently with Resident #1's discharge. She explained that she should have asked many more questions about the plan for getting Resident #1 into the home, for how his care needs would be met, and for his family members' availability to provide assistance to meet his care needs. She revealed that if she knew the wheelchair ramp was not installed, that home healthcare would refuse to provide services, and that he would not have around the clock assistance from any family member other than his elderly spouse, that she never would have discharged Resident #1 home on 8/2/21 as this was an unsafe environment. An interview was conducted with the Administrator on 8/5/21 at 11:35 AM. She was asked to explain her involvement with Resident #1's discharge planning and discharge home (8/2/21). She revealed that she was not involved in his discharge planning and that she was on vacation the week of 7/26 through 8/1/21 when the SW coordinated the discharge with him. She	F 624		

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F 624	Continued From page 26 stated that when she returned to work on 8/2/21 she learned during the morning meeting that he was being discharged home that day. She reported that this was a surprise to her as she had not expected Resident #1 to be discharged home due to his high level of care needs. The Administrator stated that when she heard he was going home she assumed that his family must have decided that they could provide the care he needed at home. She indicated that she had no further involvement with his discharge on 8/2/21. She stated that on the morning of 8/3/21 Family Member #1 phoned her as she was confused about the instructions on Resident #1's medication cards for the administration times. She stated that she explained the administration times to Family Member #1. She indicated that during this phone call she could tell by Family Member #1's voice that she was on the verge of tears so she asked her what was going on. Family Member #1 shared with her that the discharge home had been very overwhelming. She stated that it took 2 hours to get Resident #1 inside the house and that it required the assistance of the local fire department. The Administrator stated that during this phone call she told Family Member #1 that they could bring Resident #1 back to the facility. She said Family Member #1 stated that they could not afford to pay privately for him to stay at the facility. She reported that she told Family Member #1 she would have the BOM call them to discuss a Medicaid application. Family Member #1 agreed to speaking with the BOM about the Medicaid application. The Administrator indicated that she received a call from the State Survey Agency that morning and she was directed to readmit Resident #1 to the facility. She stated that she informed the State Survey Agency that the family	F 624		

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F 624	Continued From page 27 was discussing the Medicaid application and were deciding if they were going to complete it. The Administrator stated that if the family had decided not to complete the Medicaid application she would have still accepted Resident #1 back into the facility as his needs were unable to be met by the family. She explained that initially she was resistant to the thought of accepting him back without a payor source as she had not wanted the family to be stuck with a bill, but the alternative was to leave him in an environment where his needs were not able to be met. She reported that the family was hesitant to complete the Medicaid application initially as they had not understood the process and they were afraid Resident #1 and his spouse would lose their home. She indicated that the BOM and Corporate Staff spoke with the family and explained in detail the Medicaid application process and after this explanation they agreed to complete it and have Resident #1 readmitted to the facility. The Administrator reported that Resident #1 was readmitted around 6:00 PM on 8/3/21. During a follow up interview with the Administrator on 8/5/21 at 12:05 PM she stated that looking back on this discharge planning and discharge home for Resident #1 "obviously something went wrong" with the discharge planning process. She acknowledged that more information should have been found out by the SW and/or therapy about his home environment and how his care needs were going to be met. She was asked to describe the discharge planning protocol at the facility. She indicated that she was not aware of the discharge planning protocol as this was the SW's area of expertise. The Administrator was informed that the SW revealed during interview that she was not familiar with the facility's normal	F 624		

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discharge planning protocol due to being so new to the facility. She revealed that this was a surprise to her. The Administrator acknowledged that there needed to be a discharge planning process in place that included monitoring for exhaustion of benefits, notification to resident and involved family of benefit exhaustion timeframes, timelines for these notifications, some form of home assessment to receive the necessary information to determine if the home was a safe environment, and a plan for how the resident's care needs were going to be met once discharged.

An interview was conducted with the Director of Nursing (DON) on 8/5/21 at 3:45 PM. She stated that she had not been involved in Resident #1's discharge planning or discharge home. She acknowledged that there needed to be a discharge planning process in place that included monitoring for exhaustion of benefits, notification to resident and involved family of benefit exhaustion timeframes, timelines for these notifications, some form of home assessment to receive the necessary information to determine if the home was a safe environment, and a plan for how the resident's care needs were going to be met once discharged.

The Administrator and DON were notified of the Immediate Jeopardy on 8/5/21 at 3:31 PM.

On 8/5/21 at 8:00 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or

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F 624	Continued From page 29 are likely to suffer, a serious adverse outcome as result of the noncompliance. Resident #1 was discharged from the facility on 8-02-21 to home with physician orders for home health services. The resident was transported home by Transport Company that family arranged. The resident arrived at home with one caregiver present. The family was unable to get the resident into the house and called fire department for assistance. On 8-3-21 it was identified that the resident caregiver, the daughter, was unable to provide adequate assistance with incontinence care and mobility. The facility was contacted by the daughter at approximately 8:45 am that there was an issue with her dad staying in the home. The facility immediately offered to return the resident to the facility and offered the assistance of the business office in that effort. The facility called the daughter back at approximately 9:05 and left a message with the administrator's personal cell phone number in case the daughter called during morning meeting. The facility was additionally notified by the state agency at 9:30 that there was a concern. The facility, again, reached out to the family and was informed that they were having a family meeting and were not sure that they wanted to return to the facility. After several additional calls between the family and the facility the resident was re- admitted to the facility 8-3-21. Specify the action the entity will take to alter the process or system failure to prevent serious adverse outcome from occurring or recurring, and when the action will be complete. Residents being discharged have the potential to	F 624		

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be affected by the alleged deficient practice.

The facility Social Worker and Regional Director of Clinical Services reviewed every resident who has discharged home in last 30 days to ensure that a safe discharge occurred as evidenced by Quality Improvement Data Collection Form. This review included confirmation that a safe location/placement, mobility/accessibility needs can be met, medications or prescriptions provided, and all other home care needs such as appointments, home health and arrangement for medical equipment were met by completing the checklist for discharge planning.

The Social Worker and the Regional Director of Clinical Services also reviewed residents that are pending discharge to home in the next 7 days as evidenced by the discharge planning checklist. This review included a safe location/placement, mobility/accessibility needs can be met, medications or prescriptions provided, and all other home care needs such as appointments, home health and arrangement for medical equipment.
The Inter Disciplinary Team, including the Social Worker, Director of Rehab and the MDS nurses will evaluate each resident to determine if Home Evaluations Is needed by Rehab prior to discharge using home assessment questionnaire. It will be completed within 7 days of planned discharge date, by the appropriate therapy modality, ie. Physical therapy and/or occupational therapy.

Resident will be educated by nursing staff member and social services member on the healthcare consequences, and safety concerns, per checklist.

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Executive Director, Director of Nursing, MDS Nurses, Director of Rehab and Social work were educated by Regional Director of Clinical Services on discharge policies including Discharge Planning as evidenced by education in-service sign in sheet and policy and procedure for interdisciplinary discharge planning.
Residents with planned discharges will be reviewed in morning meeting when discharge date is confirmed and social worker will send notification to departments to coordinate discharge when date is confirmed to verify discharge plan is appropriate for resident needs as evidenced by the morning report form.

On admission the resident discharge goal and estimated length of stay will be established. The goals will be based upon clinical findings, availability of community and family resources, and resident and family goals. The discharge planning record will be completed within seven (7) days after admission by the Interdisciplinary Team.

The resident estimated length of stay and discharge goals will be reviewed / revised at the resident's first and subsequent team conference(s).

The IDT will meet weekly to review all residents with discharge plans to return home and how close residents are in the exhaustion of their benefits. The IDT will review and adjust, as appropriate, during weekly discharge planning meeting.
Once the date of discharge is determined the social worker will make necessary referral to outside agency to include home health, medical

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F 624	Continued From page 32 equipment and any follow up appointment. The IDT will also review with Rehab if home evaluation is appropriate. The IDT will initiate the discharge planning checklist the week prior to the discharge during the weekly discharge planning meeting. Residents who will discharge to home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs. At the time of discharge, a discharge summary and home discharge instructions will be provided to the resident and/or the resident's caregiver. Within twenty- four (24) to forty -eight (48) hours after discharge to home a follow up call will be made by the Social Worker to ascertain that community services /referrals are indeed being provided according to the discharge plan. The facility alleges the removal of Immediate Jeopardy on 8/5/21. On 8/12/21 the credible allegation of Immediate Jeopardy removal was validated by onsite verification. Evidence included a discharge planning checklist and post discharge information. The facility provided information demonstrating that 12 residents were discharged in the past 30 days had been reviewed for a safe and orderly discharge. Two residents pending discharge in the next 7 days were reviewed for safe location/placement, mobility/accessibility needs met, medications or prescriptions provided, and all other home care needs such as appointments, home health and arrangement for	F 624		

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F 624	Continued From page 33 medical equipment. Evidence included a home assessment questionnaire, Interdisciplinary discharge planning policy and procedure and a safe and orderly discharge planning in-service dated 8/5/21. Interview with the Director of Therapy on 8/12/21 at 3:56 PM revealed that the home assessment questionnaire was completed prior to each of the pending discharges since 8/5/21. She stated that additional questions would be asked as needed to ensure that residents have adequate support at home. Interview with the facility social worker on 8/12/21 revealed that she followed up with the three residents who were discharged after 8/5/21 and the residents were doing well. The facility's Immediate Jeopardy removal date of 8/5/21 was validated.	F 624		