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	345558	A. BUILDING _____ B. WING _____	C 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted on 07/20/2021. Additional information was obtained through 08/09/21. The surveyor team returned to the facility on 08/20/21 and 09/13/21 to validate the credible allegation of compliance. Therefore, the exit date was changed to 09/13/21. There were six allegations investigated and two allegatiosn were substantiated. Event ID# OGV711. Immediate Jeopardy (IJ) was identified at: CFR 483.10 at tag F 551 at a scope and severity of J. Immediate Jeopardy (IJ) began on 07/02/2021 and was removed on 08/14/21. The facility was notified on 09/03/21 of additional Immediate Jeopardy identified after CMS quality review: Immediate Jeopardy (IJ) was identified at: CFR 483.15 at tag F 624 at a scope and severity of J. Immediate Jeopardy (IJ) began on 07/16/2021 and was removed on 09/08/21.	F 000		
F 551 SS=J	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident	F 551		9/7/21

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

Electronically Signed | 09/02/2021

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must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.
(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of

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F 551	Continued From page 2 competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with resident, staff, the legal guardian (LG) with Department of Social Services (DSS) and the Medical Director, the facility failed to obtain authorization from the LG for Resident #1 to leave the facility, and to discharge out of the facility against medical advice (AMA). Resident #1 left the facility on two occasions without medications and medical care. He was evaluated at the hospital due to alcohol intoxication the first time he left the facility. The second time Resident #1 left the facility he was evaluated at the hospital for complaints of cough and chest pain and a few days later he was taken to the hospital by his LG and admitted due to alcohol consumption and subpar personal hygiene. This occurred for 1 of 3 sampled residents reviewed for the surrogate to exercise resident's rights. Immediate jeopardy began on 07/02/21 when Resident #1 exited the facility without authorization from the LG. The immediate jeopardy was removed on 08/14/21 when the facility provided and implemented an acceptable	F 551	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. The corrective action for resident #1: Resident #1 left center against medical advice (AMA) on 7/16/21 and will not be returning to the facility. The medical director for the facility entered a note that resident #1 is no longer appropriate to be at the facility. Other residents with potential to be affected: The Assistant Director of Health Services (ADHS), Nurse Navigator and RN Supervisor completed a review of all	

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F 551	Continued From page 3 credible allegation of Immediately Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: Resident #1 was admitted to the facility on 10/26/20 with diagnoses including diabetes mellitus (DM), high blood pressure, anxiety, depression, chronic obstructive pulmonary disease (COPD), supraventricular tachycardia, chronic pain, gout, and osteoarthritis. Review of the court document dated 02/17/21 indicated the court had declared Resident #1 incompetent and guardianship was granted to DSS. The quarterly Minimum Data Set (MDS) dated 04/19/21 assessed Resident #1 with moderate impairment in cognition. He required extensive assistance in bed mobility, transfer, dressing, toileting, personal hygiene, and total dependent in bathing. Resident #1 was non-ambulatory and he required a wheelchair as mobility device. A progress note charted by the Social Worker (SW) on 07/02/21 revealed Resident #1 had requested to leave the facility with a friend for a couple of hours for therapeutic leave initially. When he was leaving, he told the SW that he was going to spend the night and return on 07/03/21. An emergency department report dated 07/04/21	F 551	resident charts to determine a list of residents that were deemed a ward of the State with guardians. This was completed on Aug 9, 2021. The facility identified four other residents that have the potential to be affected by the same deficient practice. No other residents were found to be affected by the facility□s deficient practice. Social Services Director (SSD) will be notified by Admission□s Director (AD) when there is a new resident with a guardianship. SSD will update any resident with a guardian in the leave of absence books located at each nurse□s station as applicable. SSD will also indicate on the resident□s face sheet, any resident with a guardian. Measures put into place to ensure that the deficient practice will not occur: Policy and Procedure Review of AMA and LOA process will be provided to all applicable staff (nurses, social services partners, receptionist□s partners, administrator, nurse navigator and admission director). The AMA/LOA education was completed on August 13, 2021. Any new applicable staff will be made aware of residents who have a Guardian and what Guardianship means. In addition, verbal education will be provided to all applicable staff on where to find the LOA books that include a list of all residents with Legal Guardians. This education will be provided by Clinical Competency Coordinator or designee.	

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F 551	Continued From page 4 revealed Resident #1 arrived at hospital via Emergency Medical Services (EMS) with blood glucose (BG) of 170 mg/dL (milligrams per deciliter) and blood alcohol level of 231 mg/dL (value of 80 mg/dL or above is indicative of alcohol intoxication). He was awake on arrival and stated he felt fine. Resident #1 added he was just drunk as he had been drinking alcohol since the 07/03/21 morning. Physical examination ruled out any neurological deficits and signs of trauma. Basic labs did not show any new concerning findings. After about 3 hours in the emergency room (ER), Resident #1's condition improved significantly. The physician determined it was safe to discharge Resident #1 home with his friend. A nurse's note charted by Nurse #1 on 07/05/21 revealed Resident #1 returned to the facility around 1:00 PM without shoes or socks. Resident #1 stated he did not have any medications since leaving the facility on 07/02/21. Resident #1 did not show any signs of distress when he returned. His vital signs were within the normal limits except having pulse of 102 beats per minute. His blood pressure (BP) of 121/72 was within the normal range. Resident #1's BG was not assessed on return to the facility. A nurse's note charted by Nurse #1 on 07/07/21 revealed Resident #1 told her that while he was out of facility over the weekend, he was taken to the hospital via EMS due to unresponsiveness and released several hours later. He added he fell and laid in the floor before his friends arrived to assist him up. Resident #1 stated while he was lying in the floor, trailer park staff hooked a tractor to the trailer and attempted to pull the trailer off the lot, ripping the side of the trailer out and	F 551	New Nurses and any Agency Nurses will be educated on the AMA and LOA policies upon hire with coordination from our Clinical Competency Coordinator (CCC) or her designee. Monitoring of POC: SSD will monitor LOA books and applicable face sheets weekly related for any LOA/AMA discharges. The IDT team will monitor these discharges on a weekly basis to ensure that our policy and procedures on LOA and AMA are followed. This monitoring will occur for the next 12 weeks. In-service sheets from the CCC or designee will be given to the Administrator when orientation is conducted or when new Agency Nurses are contracted. The IDT team will monitor the LOA/AMA discharges each month during our QAPI meetings. The Administrator or his designee will ensure that the reviews are comprehensive and adhere to LOA/AMA policies and procedures. Correction Action Completed: 9/7/2021	

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everything off the walls fell toward him. Resident #1 indicated that he did not eat while he was in the trailer. Upon the EMS and the police officer arrival, he initially refused to transfer, stating that they would have to arrest him first. After reviewing the court declared incompetency papers, officer explained to Resident #1 that he did have to go to the ER.

Review of Brief Interview for Mental Status (BIMS) dated 07/15/21 revealed Resident #1 had scored 15 in the assessment, indicating he was cognitively intact.

Review of the Medication Administration Records (MARs) revealed Resident #1 was receiving the following medications prior to discharge on 07/16/21:

" Levemir 15 units subcutaneously (SQ) once daily at bedtime for DM.
" Novolog 4 units SQ three times daily before meals for DM.
" Metformin 1,000 milligrams (mg), 1 tablet by mouth two times daily for DM.
" Metoprolol 25 mg, one-half tablets by mouth two times daily for high blood pressure.
" Prazosin 1 mg, 1 tablet by mouth two times daily for high blood pressure.
" Ventolin, inhale 2 puffs by mouth once every 6 hours as needed for COPD.
" Ativan 0.5 mg, 1 tablet by mouth two times daily for anxiety.
" Lexapro 15 mg, 1 caplet by mouth once daily for depression.

Review of medical records dated 07/16/21 revealed the SW and Resident #1 signed the AMA form on 07/16/21 at 3:30 PM.

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A progress note charted by the SW on 07/16/21 revealed Resident #1 had checked himself out of the facility AMA at 4:15 PM. Resident #1 signed the AMA document with the full understanding that he was going against medical advice and it was not a safe discharge. It could pose a threat to his life, health, and safety. The SW reminded him that there were court documents indicating he had an appointed guardian of person. Resident #1 was made aware if he chose to discharge AMA the facility would not take him back in future. The SW called the LG at 4:25 PM and left a message.

Review of an emergency department report dated 07/17/21 revealed Resident #1 presented to the ER before midnight due to complaint of cough and chest pain. He did report shortness of breath with productive cough that became worsen with a deep breath. Resident #1 was hungry as he kept requesting food. Chest X-ray showed portion of bilateral lung passageway and lower lobes replaced with fluids, likely a combination of acute and chronic changes. He was diagnosed with community acquired pneumonia and started on oral antibiotics. He had BG of 83 mg/dL, white blood cell count of 5.8, and his vital signs were within normal limits. Resident #1 spent a night in the ER and was discharged on 07/18/21 morning. Resident #1 and his friend were instructed by the physician to return to the hospital if any symptom worsening occurred.

Interview with the SW on 07/20/21 at 10:46 AM revealed Resident #1 initially requested to go out of facility for a few hours around noon on 07/02/21. When Resident #1's friend arrived late at 4 PM, he told the SW before leaving that he

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would spend a night in his friend's house. After he had left the facility, he called for extension repeatedly. Resident #1 finally returned to the facility on 07/05/21. The SW was on a break from 07/02/21 through 07/06/21. When she returned on 07/06/21, she notified the LG immediately about the incident and indicated that it was her fault for failure to notify the LG before Resident #1 left the facility on 07/02/21. During the phone conversation on 07/06/21, the LG stated clearly that Resident #1 was not allowed to leave the facility without his permission. The SW stated she notified the LG after Resident #1 had left the facility AMA on 07/16/21. She recalled the LG had told her on 07/13/21 that she could call police if Resident #1 insisted to leave the facility. The SW stated the facility could not physically restrict Resident #1 from leaving the facility. When Resident #1 voiced his intention to discharge from the facility on 07/16/21 around 10:00 AM, she explained to Resident #1 that he had been declared deemed incompetent by the court, he had to remain in the facility as directed by the LG. The SW educated Resident #1 that he could face potential harm without medications and medical care, and he would not be allowed to return to the facility in future. He expressed understanding and agreed he would not return to the facility in future. Resident #1 stated he did not believe that court decision and he was determined to get out of the facility. Resident #1 was given a list of his medications but not the prescription or the medications as he stated he would obtain the medications from the Veterans Administration (VA) hospital. The SW explained she did not call the LG before Resident #1 left the facility as she thought Resident #1's friend might not pick him up from the facility.

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An emergency department report revealed Resident #1 arrived at ER on 07/20/21 afternoon after claiming he had been assaulted in the head with a hammer by a woman. Physical examination revealed atraumatic for head and face. Head computed tomography (CT) revealed no evidence of acute bleeding inside the skull or skull fracture. He had blood alcohol level of 63 mg/dL, BG of 102 mg/dL, and his vital signs were within normal limits. Resident #1 was also evaluated with chest X-ray and labs included complete blood count (CBC) and comprehensive metabolic panel (CMP). All the findings were unremarkable. He was ready to be discharged but had to remain in the hospital awaiting placement.

During a phone interview on 07/20/21 at 2:16 PM, Resident #1's friend who picked him up on 07/16/21 stated that the SW called him on 07/16/21 before lunch to pick Resident #1 up from the facility. The SW told him not to bring Resident #1 back to the facility after leaving the facility. He brought Resident #1 to Hickory and dropped him at his friend's house.

During an interview on 07/20/21 at 4:03 PM the Administrator stated the facility had called police when Resident #1 attempted to leave the facility with his friend on 07/13/21. The police officer told him that unless Resident #1 tried to leave the facility by using a wheelchair on the street that could endanger himself and others, he could not do anything legally against Resident #1.

During a phone interview with the DSS's attorney on 07/21/21 at 12:38 PM, he stated the court had ruled Resident #1 deemed incompetent and granted guardianship to the DSS on 02/17/21.

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The court ruling remained active.

During a phone interview with Resident #1 on 07/21/21 at 2:30 PM, he stated when he left the facility on 07/16/21, the SW gave him a list of medications but not the prescriptions nor medications. The SW and the Administrator gave him a form to sign and told him that he was okay to leave the facility. He lost the medication list after leaving the facility and was unable to obtain any medication in the VA hospital without prescriptions. He could only fill metformin in a local pharmacy as he still had refills. It was the only medication he took while away from the facility on July 4th weekend. He denied knowing any court ruling related to his incompetency and the guardianship.

Interview with Nurse #2 on 07/21/21 at 6:14 PM revealed Resident #1 was wheelchair bound and unable to care for himself. It was risky for him to leave the facility without medications and caregiver as he had heart condition and was insulin dependent.

During a phone interview with the LG on 07/22/21 at 12:45 PM, he stated the facility had failed to obtain his permission before letting Resident #1 leave the facility on 07/02/21 and 07/16/21 respectively. He had instructed the SW and the Administrator repeatedly that Resident #1 was not allowed to leave the facility without his permission unless it was for medical reason. On 07/04/21, Resident #1 was hospitalized due to alcohol intoxication. On 07/16/21, the SW called him after Resident #1 had left the facility AMA. He stated Resident #1 had no legal capacity to sign himself out AMA without his approval. The person who picked up Resident #1 on Friday (7/16/21) told

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him that the SW called him to come over to the facility to pick Resident #1 up. As Resident #1 left the facility without medications, he was hospitalized on 07/17/21 due to chest pain. He found Resident #1 on 07/19/21 in his friend's trailer. Resident #1 was without any medication including insulin, but he appeared to be okay. However, when he visited him again on 7/20/21, Resident #1 was sitting in a recliner in his own urine and feces and had been drinking. The LG called EMS to transport him to the hospital.

During a phone interview with the Medical Director (MD) on 07/21/21 at 1:48 PM, he stated Resident #1 lacked legal capacity to sign the AMA form as he was declared incompetent by the court. The only person authorized to act on Resident #1's behalf was the LG.

During a subsequent phone interview with the MD on 07/22/21 at 2:33 PM, he stated his biggest concern for Resident #1 was his DM without insulin as he was insulin dependent.

The Administrator was informed of immediate jeopardy on 08/09/21 at 2:12 PM.

The facility provided the following acceptable immediate jeopardy removal plan with the correction date of 08/14/21.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Four current residents at the facility have court appointed guardians and are at risk for adverse outcome as a result of noncompliance.

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Resident #1 left Center (AMA) on 7/16/21 and will not return to Facility. The Medical Director for the facility entered a note that the resident was no longer appropriate to be at the facility.

Resident #1 admitted to the facility on 10/26/20. His diagnoses included diabetes mellitus, anxiety, depression, COPD, hypertension, supraventricular tachycardia, chronic pain, stage 4 pressure ulcer at left hip, gout, and osteoarthritis. Review of the court document dated 02/17/21 indicated the court had declared Resident #1 deemed incompetent and guardianship was granted to Catawba County DSS.

Brief Summary of Allegation:
On 7/2/21 resident #1 stated that he was going to leave the facility for a few hours for a therapeutic leave with a friend. As resident was leaving the facility, he stated that he was going to spend the night and return on Saturday. Resident returned to facility on 7/5/21 and stated that he had not had any medications since leaving facility on 7/2/21. Facility was under impression that resident would return to facility on 7/3/21. Resident told nurse that while on LOA resident was transported to Catawba Valley Medical Center via EMS due to intoxication. Hospital records from this visit on 7/4/21 indicated that resident arrived at hospital and stated that he felt fine but was just drunk. Blood alcohol level was determined to be at 231. After returning to facility, resident notified staff that he had allegedly fallen while on leave of absence (LOA) and laid in the floor for a day until friends arrived to assist him. Hospital records indicate no evidence of skin tears, abrasions or bruising. Guardian for resident #1 was notified on 7/6/21 about LOA.

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On 7/16/21 resident #1 stated that he was going to go home. Administrator, SSD, and ADON counseled resident #1 prior to departure. Resident #1 was discharged against medical advice (AMA) from the facility on 7/16/21. At 3:30pm on 7/16/21 an against medical advice form was signed by SSD and resident #1 was clear in understanding of ramifications of decisions and voiced clarity of his intent to go home without clearance from guardian. At 4:15pm resident #1 left facility with friend. Resident was notified that resident would not readmit him if he chose to leave AMA. At 4:25pm SW attempted to notify guardian at Catawba County DSS and left a message. Emergency APS was then notified along with Buncombe County Ombudsman, resident #1's financial guardian, Buncombe County Attorney for resident #1 was notified via message. SSD received return call from guardian at which time she notified guardian of situation and that resident would not be readmitted to facility due to signing AMA.

Per survey findings, on 7/17/21, resident #1 presented to ER with complaint of productive cough, chest pain, and shortness of breath. Chest x-ray revealed portion of bilateral lung passageway and lower lobes with fluid. Resident #1 diagnosed with community acquired pneumonia and oral antibiotics initiated. Resident discharged the morning of 7/18/21 with his friend.

Per survey findings, on 7/20/21 resident #1 presented at ER claiming he had been assaulted by a female, who struck him in the head with a hammer. Physical exam and CT scan were negative. Chest x-ray and labs were unremarkable. Discharge from hospital was

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pending placement.

According to progress notes dated 7/15/21, Res #1 participated in both his BIMS and PHQ-9 assessments. He scored a 15 on his BIMS indicating that he was cognitively intact and 0/27 on his PHQ-9 confirming he was not depressed.

The Facility has identified four other residents that have a Guardian and could be at risk. However, to date, no attempts have been made by any of the four residents to leave facility without Guardian's permission.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring and when the action will be completed:

Policy and Procedure Review of AMA and LOA process was provided to all applicable staff (nurses, social services partners, receptionist's partners, administrator, nurse navigator and admission director). The AMA/LOA education was initiated on August 9, 2021 and will be completed by August 13, 2021. All applicable staff have been made aware of residents who have a Guardian and what Guardianship means. In addition, verbal education on where to find the LOA books that include a list of all residents with Legal Guardians was provided. The staff that provided all education from 8/9/2021 - 8/13/2021 comprised of the ADON, Nurse Supervisor, Nurse Navigator, the Clinical Competency Coordinator, and the QAPI nurse. Social Services Director (SSD) was notified of her LOA book updating responsibility on August 9, 2021. New Nurses and any Agency Nurses will be educated on the AMA and LOA policies upon hire with coordination

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from our Clinical Competency Coordinator (CCC) and her trained designees.

The Assistant Director of Health Services (ADHS), Nurse Navigator and RN Supervisor completed a review of all resident charts to determine a list of residents that were deemed a ward of the State with guardians. This was completed on Aug 9, 2021.

All applicable staff were provided verbal education on below: the staff that provided all education from 8/9/2021 - 8/13/2021 comprised of the ADON, Nurse Supervisor, Nurse Navigator, the Clinical Competency Coordinator, and the QAPI nurse. The Staff including the Administrator and SSD were educated that the guardian status is noted on each resident's face sheet and only guardians can make decisions for resident. SSD will be notified by Admission's Director (AD) when there is a new resident with a guardianship. The Administrator was notified of his responsibility to notify the SW of any current residents that receive a change in status related to any new guardianship. The SSD is aware of her responsibility to notify guardian of any request made by resident to leave the facility. If Social worker is not available, RN/LPN will notify guardian and document conversation. Administrator and Social Worker received the same verbal education that all staff received, and verbalized understanding. This training was commenced on August 9 and will be complete on August 13, 2021. New Nurses and any Agency Nurses will be educated on the AMA and LOA policies upon hire with coordination from our Clinical Competency Coordinator (CCC) and her trained designees.

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Education began on 8/9/21 conducted by the Assistant Director of Health Services and designees for all nursing staff including Licensed and unlicensed staff to include but not limited to:
Notification of responsible party/Guardian before leave absence
Documentation of who is taking resident from the facility
Documentation of where the resident is going and when they when return
Documentation of any medications/supplies/education provided to resident and individual taking resident from facility.

Any staff not receiving education due to scheduled time off or FMLA will be educated before their next scheduled shift. Education will also be added to new partner orientation on a go forward basis.

Education began on 8/9/21 which was conducted by the Assistant Director of Health service and designees. This education was provided to social worker, receptionists, financial counselor, and administrator to include but not limited to:

Notification of responsible party before leave absence,
Documentation of who is taking resident from the facility
Documentation of anticipated time of return
Documentation of any medications/supplies/education provided to resident and individual taking resident from facility.

Any staff not receiving education due to scheduled time off or FMLA will be educated

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before their next scheduled shift. Education will also be added to new partner orientation on a go forward basis. CCC and the ADON will tracking education as they were initially notified of this on August 10, 2021.

ADHOC Quality Assurance Performance Improvement meeting was held on 8/9/2021, conducted by the Administrator, Assistant DHS, Quality Assurance Nurse, Nurse Navigator, Social Work Director and RN Supervisor to discuss the plans and immediate interventions as indicated above.

Date of IJ removal August 14, 2021.

The facility alleged immediate jeopardy removal effective date 08/14/21.

The facility's credible allegation of immediate jeopardy removal plan with the correction date of 08/14/21 was validated on 08/20/21. The policy and procedure of AMA and leave of absence (LOA), and the LOA book that consisted of 4 residents with legal guardian were reviewed with no concerns identified. Review of the in-service records conducted from 08/09/21 through 08/13/21 revealed all the 151 staffs from different departments included nursing, social services, receptionist, admission, and management staff had completed the in service. All the participant in the in-services were educated with the AMA and LOA process, provided instructions to retrieve guardian status from the LOA book or through resident's face sheet, and instructed only the guardian could make decisions for the resident. In-service began on 08/09/21 was conducted by the Assistant Director of Health service and her trained designees. The topic of the education

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included but not limited to:
" Notification of responsible party/Guardian before the leave of absence
" Documentation of who was taking the resident from the facility
" Documentation of where the resident was going and when he/she would return
" Documentation of any medications/supplies/education provided to the resident and the individual taking the resident from the facility.

Any staff not receiving in-service due to scheduled time off or Family and Medical Leave Act (FMLA) would be educated before their next scheduled shift. Education would also be added to new partner orientation on a go forward basis. The Clinical Competency Coordinator (CCC) and the ADON would track the in-services to ensure full compliance. The SW was assigned to update the LOA book and notify the guardian of any request made by the resident to leave the facility. If the SW was not available, the hall nurse would notify the guardian and document the conversation. The Admission Director was instructed to notify the SW when admitting a new resident with a guardianship and the Administrator was responsible to notify the SW of any current residents that received a change in status related to new guardianship.

Interviews with staff on 08/20/21 revealed all the staff were required to complete an in-service related to guardianship and AMA/LOA. Staff who had completed the education from 08/09/21 through 08/13/21 were aware of the 4 residents who currently had a guardian, able to verify guardian status through face sheet, and describe what guardianship meant. The SW was able to

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F 551	Continued From page 18 verbalize her responsibility to update the LOA book and notify the guardian if any resident requested to leave the facility. The hall nurses verbalized understanding of their role to notify the guardian and document the conversation if the SW was not available. The Admission Director was aware of her responsibility to notify the SW when admitting a new resident with a guardianship. The Administrator verbalized understanding to notify the SW when residents had a change in status in guardianship.	F 551		
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 staff, resident, Physician and Legal Guardian (LG) interviews the facility failed to make provisions for Resident #1's needs for a safe discharge and did not provide him with prescriptions or medications, assess the accessibility or safety of his discharge destination, determine if he would have access to food and running water, refer him for home health services or contact the Veterans Administration (VA). The day after Resident #1 was discharged Against Medical Advice (AMA) spent a night in the emergency room (ER) due to complaint of cough and chest pain and was diagnosed with pneumonia. He was hungry while in the	F 624	The corrective action for resident #1: Resident #1 is no longer at the facility. He has been placed in another Skilled Nursing Facility (SNF). Other residents with potential to be affected: The Assistant Director on Nursing (ADON), Nurse Navigator (NN) and RN Supervisor completed a review of all resident charts to determine a list of residents that were indicating an intent to	9/24/21

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emergency room and kept requesting food. This occurred for 1 of 3 sampled residents reviewed for safe and orderly discharge.

Immediate jeopardy began on 07/16/21 when Resident #1 was discharged AMA without authorization from his LG. The immediate jeopardy was removed on 09/08/21 when the facility provided and implemented an acceptable credible allegation of Immediately Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective related to safe and orderly discharge.

The findings included:

Resident #1 was admitted to the facility on 10/26/20 with diagnoses including insulin dependent diabetes mellitus (DM), high blood pressure, anxiety, depression, chronic obstructive pulmonary disease (COPD), supraventricular tachycardia, chronic pain, gout, and osteoarthritis.

Review of the court document dated 02/17/21 indicated the court had declared Resident #1 deemed incompetent and guardianship was granted to DSS.

The quarterly Minimum Data Set (MDS) dated 04/19/21 assessed Resident #1 with moderate impairment in cognition. He required extensive assistance in bed mobility, transfer, dressing, toileting, personal hygiene, and total dependent in bathing. Resident #1 was non-ambulatory, and he required a wheelchair as mobility device. He had

discharge. This occurred on August 9, 2021. There were and are no current residents that are actively seeking discharge at this time.
Social Service Director (SSD) will notify the Interdisciplinary Team (IDT) that a discharge is pending. The particular partners of the IDT team that need to be notified are the NN, Director of Nursing (DON), the charge nurse caring for respective resident/s and the Medical Director (MD) or Nurse Practitioner (NP).

Measures put in place to ensure that the deficient practice will not occur:

Policy and Procedure (P and P) for Discharge Planning was provided by the Nurse Consultant on 9/3/21 who assisted the ADON and the NHA with the training for in-servicing that was given to the Clinical Care Coordinator (CCC), NN, and the DON. The CC, NN and DON in-serviced all applicable staff (nurses, social service partners, NHA, ADON and Admission□s Coordinator (AC). This education was completed on Sept 7, 2021. All education included notification of and permission from guardian (if applicable), Responsible Party (RP) prior to any discharge/leave of absence (LOA); safe discharge/Against Medical Advice(AMA) practices up to and including medications/medical supplies that are be sent with all discharges if those medications are available at the facility; prescriptions obtained and sent home with resident; home health set up when indicated; medication and discharge

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moderate difficulty in hearing and impaired vision. The MDS indicated Resident#1 had impairment for both sides of upper extremities. Further review of the MDS revealed Resident #1 had received antidepressant daily, antipsychotic 6 days, and opioid 1 day in the 7-day look back period.

Review of the Medication Administration Records (MARs) revealed Resident #1 was prescribed the following medications in July 2021:

Levemir 15 units subcutaneously (SQ) once daily at bedtime for DM.
Novolog 4 units SQ three times daily before meals for DM.
Metformin 1,000 milligrams (mg), 1 tablet by mouth two times daily for DM.
Metoprolol 25 mg, one-half tablets by mouth two times daily for high blood pressure.
Prazosin 1 mg, 1 tablet by mouth two times daily for high blood pressure.
Ventolin, inhale 2 puffs by mouth once every 6 hours as needed for COPD.
Ativan 0.5 mg, 1 tablet by mouth two times daily for anxiety.
Lexapro 15 mg, 1 caplet by mouth once daily for depression.

A progress note charted by the Social Service Director (SSD) on 07/16/21 revealed Resident #1 had checked himself out of the facility AMA at 4:15 PM. Resident #1 signed the AMA document with the full understanding that he was going against medical advice and it was not a safe discharge. It could pose a threat to his life, health, and safety. The SSD reminded him that there were court documents indicating he had an appointed guardian of person. The SSD called the LG at 4:25 PM and left a message.

instructions given to the resident and/or responsible party; education provided by the nurse about medication and discharge instructions given to the Guardian (if applicable), RP, and resident. Return demonstration including but not limited to safe administration of injectable medications including insulin which is demonstrated by discharging nurse. Education to Guardian/RP/resident includes signs and symptoms of hyperglycemia if applicable. Education includes possible adverse consequences of AMA discharges and consequences of discharges that do not involve guardians and families. Any staff not receiving this education due to time off or FMLA is educated at orientation or on or before their next scheduled shift. The ADON and the CCC were notified on 9/3/21 that they are responsible for tracking who has and who has not received stated training. The CCC, DON and NN were notified on 9/3/21 that hey would be responsible for providing the education for staff that did not receive education on the AMA and safe discharges upon hire, the setting up of home health, medications and any applicable durable medical equipment (DME) with coordination from our CCC or trained designees. The SSD was notified on 9/3/21 of her responsibility to facilitate any use of DME needed for the resident to safely discharge.

SSD and NN are assessing every discharge for accessibility and safety of discharge destination including access to food and running water, access to home

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F 624	Continued From page 21 Interview with the SSD on 07/20/21 at 10:46 AM revealed the LG had stated clearly during a phone conversation on 07/06/21 that Resident #1 was not allowed to leave the facility without his permission. The SSD stated she notified the LG after Resident #1 had left the facility AMA on 07/16/21. She recalled the LG had told her on 07/13/21 that she could call police if Resident #1 insisted to leave the facility. The SSD explained the facility could not physically restrict Resident #1 from leaving the facility. When Resident #1 voiced his intention to discharge from the facility on 07/16/21 around 10:00 AM, the Nursing Home Administrator (NHA), Assistant Director of Nursing (ADON) and the SSD explained to Resident #1 that he had been declared deemed incompetent by the court, he had to remain in the facility as directed by the LG. The SSD educated Resident #1 that he could face potential harm without medications and medical care. Resident #1 expressed understanding and indicated that he was determined to get out of the facility. Resident #1 stated he had a home to go to and had provided the address to the SSD. She called all the phone numbers to verify before his departure. Resident #1 was given a list of his medications but not the prescription or the medications as he stated he would obtain the medications from the VA hospital. During an interview with the Nursing Home Administrator (NHA) on 07/20/21 at 4:03 PM, he explained the facility had no capacity to keep Resident #1 from leaving as they could not physically restrain him. The NHA was aware that Resident #1 had a guardianship and a court ruling that declared his incompetency. The interview further revealed the facility tried to give	F 624	health services (if applicable). In addition, prescriptions are obtained and sent along current medications/medical supplies in facility (if applicable) NN or designated nurse educates on medications, discharge instructions prior to discharge. The SSD and NN were notified of their responsibility on 9/3/21. The DON or designee reviews the discharges completed from the previous day to ensure that all components were completed per P and P. Any findings will be brought up in the monthly Quality Assurance/Performance Improvement (QAPI) meeting. If the resident has a legal guardian, the legal guardian is notified immediately of any AMA wishes of the resident by SSD or NHA. If the facility feels that the discharge is unsafe due to the resident□s persistence, then the facility notifies Guardian (if applicable), RP, Powers of Attorney (if applicable), APS, VA, Medical Director and Ombudsman. The SSD and the NHA were notified of their responsibility on 9/3/21. ADHOC QAPI meeting was eld on 9/3/21 conducted by the NHA, ADON, CCC to in-service all applicable partners about the plans and immediate interventions of AMA and discharges as indicated. Date of POC completion: September 24, 2021	

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Resident #1 a one-day supply of medications on 7/16/21 before he left, and he stated he could get them from VA.

During a phone interview with the LG on 07/22/21 at 12:45 PM, he stated the facility had failed to obtain his permission before letting Resident #1 leave the facility on 07/16/21. He had instructed the SSD on 07/06/21 that Resident #1 was not allowed to leave the facility without his permission unless it was for medical reason. On 07/16/21, the SSD called him after Resident #1 had left the facility AMA. As Resident #1 left the facility without medications, he was hospitalized on 07/17/21 due to chest pain. He found Resident #1 on 07/19/21 in his friend's trailer. Resident #1 was without any medication including insulin, but he appeared to be okay.

During a phone interview with Resident #1 on 07/21/21 at 2:30 PM, he stated when he left the facility on 07/16/21, the SSD gave him a list of medications but not the prescriptions nor medications. The SSD and the Nursing Home Administrator gave him a form to sign and told him that he was okay to leave the facility. He lost the medication list after leaving the facility and was unable to obtain any medication from the VA hospital without prescriptions. He could only fill metformin in a local pharmacy as he still had refills. He denied knowing any court ruling related to his incompetency and the guardianship.

An emergency department report dated 07/17/21 revealed Resident #1 presented to the ER before midnight due to complaint of cough and chest pain. He did report shortness of breath with productive cough that became worsen with a deep breath. Resident #1 was hungry as he kept

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requesting food. Chest X-ray showed portion of bilateral lung passageway and lower lobes replaced with fluids, likely a combination of acute and chronic changes. He was diagnosed with community acquired pneumonia and started on oral antibiotics. He had blood glucose (BG) of 83 mg/dL, white blood cell count of 5.8, and his vital signs were within normal limits. Resident #1 spent a night in the ER and was discharged on 07/18/21 morning. Resident #1 and his friend were instructed by the physician to return to the hospital if any symptom worsening occurred.

During a phone interview with the Medical Director (MD) on 07/22/21 at 2:33 PM, he stated his biggest concern for Resident #1 was his DM without insulin as he was insulin dependent and the diagnosis of COPD. The interview further revealed since Resident #1 had been declared deemed incompetent by the court and had an appointed legal guardian, it was not ideal to let him discharge AMA. The MD stated if he was in the facility that day, he would not have signed the AMA papers.

The Administrator was informed of immediate jeopardy on 09/03/21 at 8:39 AM.

The facility provided the following acceptable immediate jeopardy removal plan with the correction date of 09/08/21.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Resident #1 is no longer a resident at the facility. The four residents that have Guardianship do not have any current plans for discharge. All other current residents at the facility have no plans for

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discharge and therefore are not at risk for serious adverse outcomes.
Resident #1 was discharged from Center (AMA) on 7/16/21.

Resident #1 admitted to the facility on 10/26/20. His diagnoses included diabetes mellitus, anxiety, depression, COPD, hypertension, supraventricular tachycardia, chronic pain, stage 4 pressure ulcer at left hip, gout, and osteoarthritis. Review of the court document dated 02/17/21 indicated the court had declared Resident #1 deemed incompetent and guardianship was granted to Catawba County DSS.

Brief Summary of Allegation:
On 7/16/21 resident #1 stated that he was going to go home. Administrator (NHA), Social Services Director (SSD), and Assistant Director of Nursing (ADON) counseled resident #1 prior to departure. Resident #1 was discharged against medical advice (AMA) from the facility on 7/16/21. At 3:30pm on 7/16/21 an against medical advice form was signed by SSD and resident #1 was clear in understanding of ramifications of decisions and voiced clarity of his intent to go home without clearance from guardian. At 4:15pm resident #1 left facility with friend. At 4:25pm SSD attempted to notify guardian at Catawba County DSS and left a message. Emergency Adult Protective Services (APS) was then notified along with Buncombe County Ombudsman, resident #1's financial guardian, Buncombe County Attorney for resident #1 was notified via message. SSD received return call from guardian at which time she notified guardian of situation. Before discharge, resident was given his list of medications and offered one day of

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medication. Safe transfer was made by nursing personnel to the vehicle of transport.

Per survey findings, on 7/17/21, resident #1 presented to ER with complaint of productive cough, chest pain, and shortness of breath. Chest x-ray revealed portion of bilateral lung passageway and lower lobes with fluid. Resident #1 diagnosed with community acquired pneumonia and oral antibiotics initiated. Resident discharged the morning of 7/18/21 with his friend.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring and when the action will be completed:

Education and training on policy and procedure for discharge planning was provided by the Nurse Consultant on 09/03/21 who assisted the ADON and NHA with the training for in-servicing that was given to the Clinical Competency Coordinator (CCC), Nurse Navigator (NN) and Director of Nursing (DON). The CCC, NN and DON will be used to in-service all applicable staff (nurses, social services partners, NHA, ADON and admission's director). The Discharge planning education is being initiated on September 3, 2021 and will be completed by September 7, 2021. All education will include notification of and permission from guardian (if applicable) and notification to Responsible Party (RP) prior to any discharge/leave of absence (LOA); safe discharge/AMA practices up to and including medications/medical supplies that will be sent with all discharges if those medications are available at the facility; prescriptions are to be obtained and sent home with resident; home health to be set up when indicated; medication

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and discharge instructions are to be given to the resident and/or responsible party; education provided by nurse about medication and discharge instructions to guardian (if applicable), Responsible Party and Resident. Return demonstration including but not limited to safe administration of injectable medications including insulin will be demonstrated to discharging nurse. Education to guardian/RP/resident will also include signs and symptoms of hyper/hypoglycemia if applicable. Education will also include possible adverse consequences of AMA discharges and consequences of discharges that do not involve guardians and families. Any staff not receiving education due to scheduled time off or FMLA will be educated before their next scheduled shift. The ADON and the CCC were notified 9/3/2021 that they will be responsible for tracking who has and who has not received stated training. The CCC, DON and NN were notified they would be responsible for providing the education for staff that did not receive education on 9/3/2021. New Nurses, any Agency Nurses and applicable new hires will be educated on the AMA and safe discharges upon hire and the setting up of home health, medications, and any applicable durable medical equipment (DME). with coordination from our Clinical Competency Coordinator (CCC) and her trained designees. The SSD has been notified on 9/3/2021 of her responsibility to facilitate any use of (DME) equipment needed for a resident discharging.

Social Service Director (SSD) and/or Nurse Navigator (NN) will assess on every discharge the accessibility and safety of discharge destination; determine if resident will have access to food and running water; refer to Home Health Services (if

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applicable); ensure prescriptions are obtained to be sent with the resident as well as current medications/medical supplies in facility (if applicable); NN or designated nurse will educate on medications and discharge instructions prior to discharge. The SSD and the NN were educated on their responsibility on 9/3/2021.

The Director of Nursing (DON) or designee will review the discharges completed from the previous day to ensure that all components were completed per policy. The findings will be brought to the monthly Quality Assurance/Performance Improvement (QAPI) meeting. The DON was educated on her responsibility on 9/3/2021.

If the resident has a legal guardian, the legal guardian will be notified immediately of any AMA wishes of the resident by SSD or NHA. If the facility feels that the discharge is unsafe, but the resident persists, then facility will notify Guardian (if applicable), responsible party, Power of Attorneys (if applicable), APS, VA, Medical Director, Ombudsman and Facility Administration. The SSD and the NHA were notified of their responsibility on 9/3/2021.

ADHOC Quality Assurance Performance Improvement meeting was held on 9/3/2021 conducted by the Administrator, Assistant DON and Clinical Competency Coordinator (CCC) to in service all applicable partners about the plans and immediate interventions of AMA and discharges as indicated above.

Immediate jeopardy Removal date: September 8, 2021.
The facility alleged immediate jeopardy removal effective date: September 8, 2021.

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The credible allegation of compliance with an immediate jeopardy removal date of 09/08/21 was validated on 09/13/21. The policy and procedure titled "Discharge planning" revised on 06/30/21 and "Refusal of care against medical advice" revised on 10/01/15 were reviewed with no concerns identified. Review of the in-service records conducted from 09/03/21 through 09/06/21 revealed all the 34 applicable staffs included nursing, social services, admission, DON, ADON, and the Administrator had completed the in-service. All the participants in the in-service had reviewed the policy and procedure for discharge planning and received training to conduct a safe discharge.

In-service that began on 09/03/21 was conducted by the DON, CCC and NN. The topic of the education included but not limited to:

-Notification of and permission from guardian (if applicable) and Responsible Party (RP) prior to any discharge/leave of absence (LOA).
-Safe discharge/AMA practices up to and included sending medications/medical supplies with all discharges if those medications were available at the facility.
-Prescriptions were to be obtained and sent home with Resident.
-Set up home health when indicated.
-The discharging nurse provided education related to medications and discharge instructions to the Resident and/or RP/guardian.
o Solicited return demonstration including but not limited to safe administration of injectable medications such as insulin by the Resident and/or RP/guardian.
o Provided education to Resident and/or

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RP/guardian to identify signs and symptoms of applicable conditions such as hyperglycemia or hypoglycemia.
o Counseled Resident and/or RP/guardian for possible adverse consequences of AMA discharges and discharges that do not involve guardians and families.

Any applicable staff not receiving education due to scheduled time off or Family and Medical Leave Act (FMLA) would be educated before their next scheduled shift. The ADON and the CCC was responsible for tracking all the applicable staffs to ensure the stated training was received. The CCC, DON and NN were responsible for providing the education for staff who did not receive the in-service on 09/03/21. New nurses, agency nurses and applicable new hires would be educated on the AMA and safe discharges, setting up of home health, medications, and applicable durable medical equipment (DME) with the coordination from CCC and her trained designees during orientation. The SSD was responsible to facilitate DME needs for the discharging resident. The DON or designee was responsible to review the discharges completed from the previous day to ensure all components were completed per policy. The findings would be brought to the monthly Quality Assurance/Performance Improvement (QAPI) meeting.

Interviews with the applicable staffs on 09/13/21 revealed all the applicable staff who were required to complete the in-service related to discharge planning had completed the education from 09/03/21 through 09/06/21. The SSD was able to verbalize her understanding to assess the accessibility and safety of discharge destination

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F 624	Continued From page 30 for every discharge; access to food and running water; refer to Home Health Services (if applicable); ensure prescriptions were obtained and to be sent with the Resident and facilitate the availability of medical supplies (if applicable) during discharge. All the nurses were aware of their responsibilities to provide discharge instructions to Resident and/or RP/guardian on medications, safe administration of injectable medications, identification of signs and symptoms of applicable conditions, and possible adverse consequences of AMA without RP/guardian prior to discharge. The CCC verbalized understanding to provide education and tracking in-service related to safe discharge for all the applicable staff. The ADON and DON were unavailable for an interview. The NHA expressed understanding to notify the legal guardian immediately of any AMA wishes of the resident and ensure all the discharges were safe per policy.	F 624		