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	345419	A. BUILDING _____ B. WING _____	C 11/21/2023

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted 11/20/2023 to 11/21/2023. Event ID #F1SQ11. The following intake was investigated: NC00209903. 1 of 4 complaint allegations resulted in a deficiency.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660		12/8/23

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

Electronically Signed | 12/06/2023

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F 660	Continued From page 1	F 660		

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

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F 660	Continued From page 2 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and Family Member, staff, and Nurse Practitioner interviews the facility failed to provide a safe discharge for 1 of 3 residents (Resident #1) reviewed for discharge from the facility. Resident #1 was discharged home on 11/14/2023 to an independent living apartment with Family Member #1 who was not capable of providing care and the facility did not notify Adult Protective Services the resident discharged without a care giver that could provide toileting and bathing. Resident #1 fell and was transported to the hospital shortly after arriving home from the facility. Findings included: Resident #1 was admitted to the facility on 10/23/2023 with diagnoses of necrotizing enterocolitis (inflammation of the bowel) which resulted in surgical intervention. An admission Minimum Data Set Assessment dated 10/30/2023 indicated Resident #1 was cognitively intact and required moderate assistance with upper body bathing and dressing, maximum assistance with lower body bathing and dressing, and was dependent for toileting. The assessment further indicated Resident #1 was dependent for toileting and car transfers. Resident #1's discharge Minimum Data Set	F 660	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F660 POC 1. The facility failed to notify Adult Protective Services for a patient who discharged home with family however required more assistance. 2. Discharges to the community are at risk to be affected. An audit of discharges after 11/21/2023 was completed by the Director of Nursing to ensure Adult Protective Services had been notified if needed. 3. The current discharge planner was educated by the facility administrator on 12/05/2023 regarding safe discharge process and how to determine the need for Adult Protective Services involvement. Future discharge planners to receive training during orientation to ensure necessary notifications to APS are performed when deemed necessary.	

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F 660	Continued From page 3 Assessment indicated he continued to be cognitively intact, moderate assistance for bathing and dressing upper body, maximal assistance for lower body bathing and dressing, and moderate assistance for toileting and care transfers. During an interview with the Social Worker on 11/20/2023 at 1:52 pm she stated she discussed discharge plans with Resident #1 and Family Member #1 on 10/30/2023 and they planned for Resident #1 to return home after he completed therapy and was released from the facility. The Social Worker also stated Family Member #1 stated she would be with Resident #1 at home when he was discharged from the facility. The Social Worker met again on 11/9/2023 with Resident #1 and Family Member #1 and explained to them his insurance was denying payment beginning 11/11/2023 and Resident #1 and Family Member #1 decided to appeal. The Social Worker stated she explained to Resident #1 and Family Member #1 that Resident #1 could remain in the facility, but the insurance would not pay for Resident #1's stay. The Social Worker stated on Friday, 11/10/2023, Family Member #1 told her they decided to pay privately, and Resident #1 planned to stay at the facility for a few more days to appeal a second time with the insurance but when she returned to work on Monday, 11/13/2023, Family Member #1 stated she spoke with Family Member #3, and they were going to take Resident #1 home. The Social Worker stated she explained to Family Member #1 and Resident #1 that they needed to get home health and durable medical equipment ordered before Resident #1 went home and asked if they would stay until 11/14/2023 and they agreed. The Social Worker stated she did not call Adult	F 660	4. Current Interdisciplinary team will be educated by facility administrator on 12/05/2023 on what constitutes a safe discharge and when Adult Protective Services will be notified for discharge. Discharges will be discussed by the Interdisciplinary team each morning Monday-Friday during morning stand up meeting. The team will decide if Adult Protective Services will need to be contacted. The discharge planner will be responsible for contacting adult protective services if needed. 5. Five discharges per week (or less if discharged number is less than 5) will be reviewed for the need of Adult Protective Services by the Regional Discharge Planning Specialist or designee. Five discharges per month for 2 additional months will be reviewed. Review of findings will be presented during QAPI meeting at the end of monitoring period and changes made if further issues identified. 6. Date of compliance is December 8, 2023 The Administrator is responsible for implementing the acceptable plan of correction.	

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F 660	Continued From page 4	F 660		

Protective Services when Resident #1 was discharged because the wife was with him, and Family Member #2 stated he would be checking on Resident #1.

A Notice of Medicare Non-Coverage form was signed by Resident #1 on 11/9/2023 and it stated his last covered day was 11/11/2023.

On 11/14/2023 at 8:43 pm a Provider Note written by the Nurse Practitioner stated Resident #1 weighed 358 pounds and was 6' 3" tall. The Provider Note further stated Resident #1 planned to discharge home with family support.

A Physician's Order written 11/14/2023 stated Resident #1 would receive home health services to include Physical Therapy to evaluate and treat; Occupational Therapy for Activities of Daily Living; Speech Therapy for Cognition; nursing for disease and medication management; and a Nurse Aide for activities of daily living.

Nurse Aide #1 was interviewed on 11/20/2023 at 5:42 pm and she stated she took care of Resident #1 throughout his stay at the facility. She stated when Resident #1 was discharged could transfer to the wheelchair with supervision and could take a few steps, but she had not assisted him more than a few steps since physical therapy was working with him. She stated he could wash his face, arms, and chest but he was dependent with his lower body for bathing, dressing, catheter care, and toileting, and he was able to comb his hair and brush his teeth with setup by staff.

On 11/20/2023 at 12:41 pm the Occupational Therapist Assistant (OTA) was interviewed and

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F 660	Continued From page 5	F 660		

stated Resident #1 progressed well with Occupational Therapy (OT). She stated when Resident #1 admitted to the facility he required maximum assistance with transfers from the bed to the commode or wheelchair and when he discharged on 11/14/2023 he required contact guard assistance (he could complete the task with someone supervising him and providing touch to guide him). The OTA stated the person assisting him would not need to bear his weight. The OTA stated Resident #1 would get dizzy and fatiqued if he stood for too long and she did not feel like he was strong enough to leave the facility and needed continuous care. When she voiced her concerns to Family Member #1 she stated Family Member #1 stated they were considering hiring assistance in the home. The OTA stated Resident #1 was a large man (over 6 feet tall and over 250 pounds, and Family Member #1 was small and required a walker to ambulate and she told Resident #1 and Family Member #1 she did not recommend he leave the facility because Resident #1 needed 24-hour care.

The Physical Therapist Assistant (PTA) was interviewed on 11/20/2023 at 1:00 pm and stated he treated Resident #1 throughout his stay at the facility. The PTA stated Resident #1 required maximum assistance with transfers and he was just taking a few steps when he was admitted to the facility. He stated Resident #1 could walk 5 to 29 feet, and had walked 82 feet on one occasion, during his treatments but he became very fatigued quickly when standing because he would hold his breath and had to be reminded to breath while standing. The PTA stated his endurance and ability with walking and transferring varied from day to day, and Resident #1 was not safe to go home without 24-hour care and he was shocked when his insurance appeal was denied.

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F 660	Continued From page 6	F 660		

The PTA also stated he had not worked with Resident #1 with going up and down steps and car transfers because he was not strong enough to work on those tasks before he discharged.

A Discharge Instruction and Plan of Care dated 11/14/2023 was signed by Family Member #1 and instructions for Resident #1's oxygen (which he had at home before admission the hospital), wound care, prescriptions, current med list, and instructions to follow-up with urology. The Discharge Instructions also stated Physical Therapy recommended home health to set up safe environment and establish a physical therapy plan because Resident #1's overall functional activity goes from one extreme to another; and Occupational Therapy recommended 24-hour care and durable medical equipment (bariatric wheelchair and bariatric bedside commode) and a home care nurse aide for assistance with care tasks.

On 11/20/2023 at 10:40 am the Family Member #2 was interviewed by phone and stated Resident #1 was sent home from the facility after she told the facility he was not going to have 24-hour care and they discharged him anyway. Family Member #2 stated Resident #1 was transferred home by Family Member #1 and Family Member #3. Family Member #2 stated Resident #1 became dizzy and weak and fell shortly after arriving home and was sent to the emergency department by emergency medical services and admitted to the hospital.

On 11/20/2023 at 3:48 pm the Unit Manager stated she discharged Resident #1 home with Family Member #1 and Family Member #3 on 11/14/2023. She stated Family Member #1

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F 660	Continued From page 7	F 660		

signed the discharge instructions and she received a copy of them. Nurse #1 stated she was not concerned about Resident #1 discharging home because Family Member #1 was with him, and Family Member #3 stated he would be checking on them.

During an interview on 11/20/2023 at 5:15 pm with the Director of Nursing (DON) she stated Family Member #1 stated she would be with Resident #1 and Family Member #3 stated he would be checking on them frequently she was not concerned when they decided to take Resident #1 home. The DON stated the facility set up home health services that included a Nurse Aide and Nurse for personal care and dressing changes. The DON stated they did not consider calling Adult Protective Services because he was discharged back to a similar situation and level of care he required before hospitalization with Family Member #1. The DON stated when Resident #1 decided to discharge home on 11/13/2023 they had asked him to stay until 11/14/2023 so that the appropriate services could be put into place.

The Nurse Practitioner was interviewed on 11/21/2023 at 10:39 am and she stated when Resident #1 arrived at the facility he planned to discharge home after he was able to walk short distances in the home. She stated he had progressed but had some issues with endurance. The Nurse Practitioner stated she observed him transferring without assistance from the wheelchair to the bed after therapy services with the staff providing only assistance with moving his catheter bag from the wheelchair to the bed. The Nurse Practitioner stated Family Member #1 told her she would be with the resident at all times

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F 660	Continued From page 8 when he was discharged, and Family Member #3 checked on them frequently. The Nurse Practitioner stated the family was very attentive and would have voiced concerns if they had any. The Nurse Pracitioner stated with the home health services and equipment she felt Resident #1 had a safe discharge and his wife was able to call for assistance if needed. An Emergency Department to Hospital Admission Note dated 11/14/2023 indicated Resident #1 had a urinary tract infection when he was admitted to the hospital after being discharged home and then sent to the hospital via emergency services.	F 660		