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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 12/12/23 through 12/13/23. Additional information was obtained on 12/14//23. Event ID# 46FG11. The following intake was investigated NC00210484. One (1) of the 1 complaint allegation resulted in a deficiency. | F 000 | | |
| F 622 SS=D | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; | F 622 | | 1/3/24 |

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

Electronically Signed | 01/11/2024

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or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of

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| F 622 | Continued From page 2<br>this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, hospital case manager, physician, and staff interviews, the facility discharged a resident when the resident was sent out to the local hospital for a physician ordered geriatric psychiatric consult. There was also no documentation by the physician stating the reason for the discharge or details about how the facility could not meet the resident's needs or how the resident endangered other residents for 1 of 2 sampled residents reviewed for transfer and discharge (Resident #1) .<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 4/5/23 to an unlocked unit with diagnoses that included unilateral primary osteoarthritis-right hip, history of other toxic encephalopathy, unspecified atrial fibrillation, major depressive disorder, anxiety disorder, insomnia, and delirium due to known physiological condition. | F 622 | 1. Resident #1 began having increased behaviors on 11/16/2023 and was unable to be redirected by staff. Resident #1 was throwing things at staff, refusing medications and treatment. We were concerned for her safety, the safety of our other residents and our staff. On 11/20/23 the social worker spoke with the hospital inpatient Geri psych facility regarding placement. On 11/21/23 a care conference was held with the daughter regarding placement in the Geri psych unit. Resident #1□s daughter was agreeable and 30-day discharge notice was reviewed and signed.<br>Non-emergency transport took resident on 11/22/23. A 30-day discharge notice was sent with Resident #1 due to the facility being under the impression she would be admitted for inpatient treatment.<br>All hospital transfers and discharges from | |

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| F 622 | Continued From page 3<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/14/23 revealed Resident #1 was cognitively intact. The MDS further coded Resident #1 for delusions and no physical or verbal behavioral symptoms directed towards others.<br><br>Resident #1's psychiatric service note dated 11/4/23 revealed Resident #1 was seen for a psychiatric evaluation for management of medication for psychiatric issues as the facility was utilizing a new psychiatric provider. The facility's Psychiatric Mental Health Nurse Practitioner (PMHNP) reported history of major depressive disorder, anxiety, insomnia, and anorexia and behaviors to include yelling, throwing things, and combativeness. PMHNP agreed with diagnosis and was unclear if Resident #1 had psychosis. No medication changes were suggested.<br><br>Resident #1's psychiatric service note dated 11/21/23 revealed Resident #1 was seen for a recent episode where she, per staff, attempted to throw silverware at another resident and continued to have behaviors that were not redirectable. The facility's PMHNP reported that per the SW, consideration was given to a 30-day discharge notice. The PMHNP agreed Resident #1 could be sent to ER for further psychiatric evaluation and possible hospitalization to stabilize underling psychiatric issues. No medication changes were suggested.<br><br>Review of a Nursing Home notice of transfer/discharge revealed the date of notice was 11/21/23 and the discharge date was 12/21/23. The reasons for discharge were | F 622 | the last 3 months were reviewed by the Administrator and Social Worker on 1/3/2024 and no other resident was transferred to the hospital with a 30-day discharge notice.<br><br>2. The Regional Operator provided education on 1/3/2024 to the Administrator, Social Worker, and Director of Nursing regarding the differences between transfers, bed holds, and discharges. Education included: when a resident is sent to the hospital it is a transfer and not a discharge. A notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer and copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.<br><br>3. The Administrator, Director of Nursing and or designee will audit transfers and discharges to the hospital weekly for 3 months.<br><br>4. Administrator, Director of Nursing, or designee will bring audits to 3 consecutive QAPI meetings. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.<br><br>Date of Compliance: 1/3/2024 | |

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marked as "it is necessary for your welfare and your needs cannot be met in this facility, the safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident, and the health of the individuals in this facility would otherwise be endangered." The discharge location was listed as Hospital Inpatient "Gero Psych."

Review of the Social Worker's (SW) progress note dated 11/21/23 revealed a care conference with Resident #1's family member was held regarding the facility issuing a 30-day discharge notice from the facility effective 12/21/23. Resident #1 would be discharged because the facility was not able to meet Resident #1's needs as resident needed geriatric psychiatric services as requested by the facility provider, the safety of the individuals in the facility were endangered due to clinical or behavioral status of the Resident #1, and the health of individuals in this facility would otherwise be endangered. Resident #1's daughter stated she understood as she was made aware by the nursing staff of Resident #1's combativeness towards residents and staff members. The facility Physician's Assistant (PA) requested a geriatric psychiatric consult as Resident #1 was to be discharged to inpatient geriatric psychiatric unit. A copy of the 30-day discharge letter was mailed to Resident #1's daughter and a copy was given to Resident #1.

A review of Resident #1 physician order dated 11/21/23 read geriatric psychiatric consult.

There were no physician progress notes stating the reason for the discharge or details about how the facility could not meet Resident #1's needs or how Resident #1 endangered the other residents

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located in the medical record.

The discharge MDS dated 11/22/23 indicated that Resident #1 was discharged to inpatient psychiatric facility.

Nursing progress note dated 11/22/23 at 8:39am indicated Resident #1 was discharged from the facility at 7:30am and the ambulance arrived and provided her transportation to geriatric psychiatric hospital. Resident #1 was discharged with her belongings including glasses, dentures, and phone.

Review of the hospital records revealed Resident #1 was medically evaluated in the Emergency Room (ER) on 11/22/23 for a psychiatric evaluation and Resident was documented as medically stable, and appropriate for behavioral health evaluation. In addition, medical provider note dated 11/29/23 revealed that Resident #1 initially presented to the ER on 11/22/2023 from local rehab unit after reportedly exhibiting combative and aggressive behaviors towards staff and other residents, progressively worsening over the past several weeks. Resident #1 was evaluated by the ER provider and psychiatry and was cleared for discharge, however unfortunately the local rehab unit would not accept her back. Resident #1 remained in the ER while awaiting other nursing facility placement. The medicine team was asked to admit the patient to the medical unit after 8 days. Resident #1 was diagnosed with acute urinary cystitis and received treatment. Hospital note dated 11/30/23 continued that Resident #1 was discharged to another skilled nursing facility.

An interview with the SW on 12/12/23 at 12:43pm

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revealed Resident #1 needed a geriatric-psychiatric facility-a higher level of care. The SW stated that she called the hospital behavioral psychiatric hotline on 11/20/23 and spoke to an intake hospital representative. The intake hospital representative advised the SW to send Resident #1 to the ER and she would be evaluated for the geriatric-psychiatric unit. She sent Resident #1's belongings to the ER because the responsible party did not elect for a bed hold. The SW indicated she emailed the 30-day discharge notice to the Ombudsman and the responsible party.

An interview with the Hospital Case Manager on 12/12/23 at 1:38pm revealed Resident #1 was sent to the ER on 11/22/23 with all her belongings. After evaluation, Resident #1 did not meet the criteria for geriatric psychiatric unit and needed to return to the facility. She revealed that she had spoken to the social worker at the facility regarding Resident #1's discharge on 11/27/23.

An interview with the Medical Director (MD) on 12/13/23 10:10am revealed Resident #1 had a history of challenging behaviors. It was the understanding of the MD that Resident #1 would be sent to the ER and would be evaluated and admitted to the geriatric psychiatric unit. The MD spoke to the ER physician on 11/27/23 and understood that the resident received multiple IM injections and Resident #1 was not appropriate for the facility at that time.

An interview with the Administrator on 12/13/23 11:10am revealed Resident #1's care was outside of the facility's scope. She stated the DON would be better suited to answer questions about what care the facility could not provide for Resident #1.

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| F 622 | Continued From page 7<br>The Administrator explained that the facility had to give a 30-day discharge notice to any resident who needed to go out for treatment.<br><br>An interview with the Director of Nursing (DON) on 12/12/23 at 12:59pm revealed that he was not directly involved with this discharge. He stated that he spoke to Resident #1's daughter about the discharge notice and noted Resident #1 was exhibiting acute psychosis.<br><br>A continued interview with the DON on 12/13/23 at 11:43am revealed the facility would always send a 30-day discharge notice to all residents who went to the hospital and was not aware of any resident who appealed the notice. | F 622 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and | F 867 | | 1/8/24 |

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information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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| F 867 | Continued From page 10<br>governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the Focused Infection Control and Complaint Investigation survey conducted on 1/19/21 and the Complaint Investigation survey conducted on 12/14/23. This was for a repeat deficiency in the area of Transfer and Discharge Requirements that was originally cited on 1/19/21 during the Focused Infection Control and Complaint Investigation survey, and subsequently recited during the Complaint Investigation survey completed on 12/14/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.<br><br>The findings included:<br><br>This tag is cross referenced to:<br><br>F622- Transfer and Discharge Requirements:<br>Based on record review, hospital case manager, physician, and staff interviews, the facility | F 867 | 1. On 1/9/24, The Medical Director was notified by the Administrator of the repeat citation, F622 as well as the plans to correct the cited issue.<br>On 1/9/24, the Interdisciplinary Team (IDT) conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citation F622 and the necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. This was presented by the Regional Operator and QAPI.<br><br>2. The Administrator initiated an in-service to all administrative staff on 1/8/2024 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 867 | Continued From page 11<br>discharged a resident when the resident was sent out to the local hospital for a physician ordered geriatric psychiatric consult. There was also no documentation by the physician stating the reason for the discharge or details about how the facility could not meet the resident's needs or how the resident endangered other residents for 1 of 2 sampled residents (Resident #1) reviewed for transfers and discharges.<br><br>During the Focused Infection Control and Complaint Investigation survey conducted on 1/19/21 the facility failed to communicate a Resident's guardianship status to the hospital and failed to arrange for a supervised transfer and handoff of the Resident who was deemed incompetent and had a legal guardian. The nursing home provided confidential guardianship information to a contracted van driver in a sealed envelope. The van driver reportedly provided the sealed envelope to hospital staff and left the resident alone at the hospital. Hospital staff denied receiving any resident documentation in written, scanned, or telephonic format. This was evident for 1 of 3 residents reviewed for hospital discharges and transfers. | F 867 | the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary.<br>All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education.<br><br>3. The QAPI Committee will review the compliance audits for F622 to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance.<br><br>4. The Administrator will be responsible for the plan of correction and ensuring all audits are completed by the QAPI Committee.<br><br>Date of Compliance: 1/8/2024 | |