| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted from 03/17/24 through 03/23/24. Event ID# VOKY11. The following intake was investigated NC00214586. Intake NC00214586 resulted in immediate jeopardy.<br><br>1 of the 1 complaint allegation resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.21 at tag F660 at a scope and severity J<br><br>Immediate Jeopardy began on 02/27/24 and was removed on 03/22/24. | F 000 | | |
| F 579 SS=D | Posting/Notice of Medicare/Medicaid on Admit<br>CFR(s): 483.10(g)(13)<br><br>§483.10(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and family member interviewa, staff interviews and record review the facility failed to provide a resident with information regarding application for Medicaid for 1 of 1 resident reviewed for discharge (Resident #1).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility from the hospital on 01/15/24. | F 579 | The facility failed to offer Medicaid to resident<br>#1 and failed to assist him to apply for Medicaid.<br><br>Corrective action for affected resident:<br><br>Resident #1 readmitted to the facility on 3/25/24. Medicaid application has been completed and the resident is pending | 4/9/24 |

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

Electronically Signed | 04/10/2024

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| F 579 | Continued From page 1<br><br>Resident #1's last date of skilled nursing services ended on 02/22/24 and he was discharged to his home on 02/27/24.<br><br>During an interview with Resident #1 on 03/18/24 at 10:45 AM he stated the Social Worker (SW) and the Business Office Manager (BOM) told him and his Family Member the facility did not do the Medicaid application. The SW told them they would have to apply for community Medicaid on their own.<br><br>An interview was conducted with Resident #1's Family Member on 03/18/24 at 4:51 PM. He stated he tried to get the BOM to help file for Medicaid and she said "Oh, we can't do that" and the Social Worker said she could not help either.<br><br>During an interview with the Social Worker on 03/19/24 at 10:20 AM, she stated she did not assist Resident #1 with a Medicaid application. She further stated the BOM was responsible for Medicaid applications.<br><br>On 03/19/24 at 12:08 PM an interview was conducted with the BOM. She stated she helped residents who were going to stay in the facility for long term care or if they were going to stay at the facility an extended period. She said she did not typically just help a resident apply for Medicaid. She stated she could fax in a Medicaid application, but it would be for the community. The BOM said when Resident #1's Family Member asked her and the SW about Medicaid, she explained Medicaid was based on monetary amounts that they must be under to qualify. She said she told the Family Member he could apply but he said Resident #1 made too much money. | F 579 | approval<br><br>How will the facility identify other like residents:<br><br>To identify other residents that have the potential to be affected, on 3/19/24 the business office manager offered the option of Medicaid to all current residents in the facility who do not already have Medicaid. Any resident wishing to apply for Medicaid was assisted with the application process.<br><br>What will facility do to prevent this from recurring:<br><br>To prevent this from recurring on 3/19/24 the Regional Director of Clinical Services educated the Administrator, business office manager, and social worker to offer all residents the option of applying for Medicaid, and if they wish to apply for Medicaid, the business office will assist them with the application process.<br><br>How will the facility monitor and maintain ongoing compliance:<br><br>To monitor and maintain ongoing compliance beginning 4/1/24 the administrator or designee will audit 5 resident records per week to ensure that Medicaid has been offered and the facility assisted in the application process. Audits will continue for 12 weeks<br><br>QAPI: | |

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| F 579 | Continued From page 2<br>The BOM stated the day the Family Member asked about Medicaid the facility had already issued the anticipated discharge date. The BOM stated she recommended Resident #1 get in touch with the Department of Social Services to find available programs because she did not deal with community Medicaid.<br><br>An Interview with the Administrator on 03/19/24 at 4:05 PM revealed she was not aware Resident #1, or his Family Member had asked the SW or BOM about Medicaid. She added Resident #1 wanted to go home so he would have needed to apply for community Medicaid. | F 579 | The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.<br><br>Results from audits will be brought to the monthly QAPI meeting x 3 months.<br><br>AOC 4/9/24 | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be | F 623 | | 4/9/24 |

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| F 623 | Continued From page 3 | F 623 | | |

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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| F 623 | Continued From page 4<br>disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and family member interviews, the facility failed to provide the resident a notification of discharge and did not send a copy of the notice to the Ombudsman for 1 of 1 residents (Resident #1) reviewed for | F 623 | The facility failed to issue resident #1 a 30 day discharged notice in writing prior to discharging him home.<br><br>Corrective action for affected resident: | |

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| F 623 | Continued From page 5<br>discharge.<br><br>Findings included:<br><br>Resident # 1 was admitted to the facility on 1/15/24.<br><br>A review of the medical record review of the admission Minimum Data Set (MDS) assessment dated 1/21/24 revealed Resident #1 was cognitively intact.<br><br>A record review revealed Resident #1 was his own responsible person.<br><br>An interview on 03/18/24 at 10:45 AM with Resident #1 revealed he was aware he was to be discharged on 02/27/24 but he did not receive a written notification of his discharge.<br><br>An interview on 03/19/24 at 10:20 AM the facility Social Worker (SW) revealed the facility did not send a written notice of transfer/discharge with Resident #1 or send a copy of the written notices to the Ombudsman. She stated Resident #1 was an insurance-initiated discharge and she was not required to provide one.<br><br>An interview was conducted on 03/18/24 at 5:30 PM with the Administrator and she stated Resident #1 was an insurance-initiated discharged. No written notice of transfer/discharge was provided because he was insurance cut.<br><br>On 03/19/24 at 9:00 AM an interview was conducted with the regional director of clinical services, and she stated the facility did not issue a 30 written discharge/transfer notice. She stated | F 623 | Resident #1 readmitted to the facility on 3/25/24.<br><br>How will the facility identify other like residents:<br><br>To identify other residents that have the potential to be affected, on3/20/24 the administrator or designee contacted all residents/resident representative who had discharged in the last 90 days to ensure they had access to their medications, equipment, home health, a working phone, and their activity of daily living care needs are being met. No other issues were identified and no other residents required readmission to the facility.<br><br>What will the facility do to prevent this from recurring:<br><br>To prevent this from recurring, the Regional Director of Clinical Services educated the Administrator, business office manager, and social worker on the criteria of a 30 day discharge notice. Discharges will be reviewed in clinical morning meeting for the need to issue a 30 day discharge notice. If a resident meets the criteria for a 30 day discharge notice, the social worker or the administrator will contact the State Long-Term Care Ombudsman prior to the 30 day discharge being issued and transfer of that resident.<br><br>How will the facility monitor and maintain ongoing compliance: | |

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| F 623 | Continued From page 6<br>the insurance-initiated discharge was because Resident #1's insurance issued a cut off notice that they were no longer going to pay. She stated the SW issued a Notice of Medicare Non-Coverage (NOMNC) that was generated from the insurance. She said the only time the facility issued a 30-day notice was if the resident was a danger to other residents or for non-payment. She stated for non-payment the resident had to have stayed 30 days and not paid for the 30 days. | F 623 | To monitor and maintain ongoing compliance beginning 4/1/24 the administrator or designee will audit 5 resident records per week to ensure that the resident met the criteria for issuing a 30 day discharge notice, and if the notice was issued. Audits will continue for 12 weeks.<br><br>QAPI:<br><br>The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.<br><br>Results from audits will be brought to the monthly QAPI meeting x 3 months.<br><br>AOC 4/9/24 | |
| F 660 SS=J | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>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-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each | F 660 | | 4/9/24 |

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| F 660 | Continued From page 7 | F 660 | | |

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 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

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| F 660 | Continued From page 8<br>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.<br>(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 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, ombudsman, family, friend, staff, the Home Health Nurse, and Adult Protective Services Social Workers interviews the facility failed to develop and implement an effective discharge planning process for 1 of 3 residents, Resident #1, by not assessing the home environment which was described as not safe by the resident and family, discharging the resident to home where the resident did not have a functional phone to contact people or 911 in the event of an emergency and arranging for individuals who would be able to obtain the resident's prescription medications and assist with basic Activities of Daily Living (ADLs) such as transfer from the couch to a wheelchair, toileting, peri-care, meal preparation, and bathing. The facility failed to | F 660 | The facility failed to implement an effective discharge plan for resident #1resulting in a re-hospitalization to the hospital.<br><br>Corrective action for affected resident:<br><br>Resident #1 was discharged home on 2/27/24 and transported back to the hospital later the same day. He has been re-admitted back to the facility on 3/25/24.<br><br>How will the facility identify other like residents:<br><br>To identify other residents that have the potential to be affected, beginning 3/19/24 | |

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| F 660 | Continued From page 9<br>realize the risk the resident was being placed at by being discharged to home without on-site assistance despite adult protective services being involved with the resident, family members stating the resident would be unable to care for himself, the resident not being able to function independently at the facility, and the resident stating he was not comfortable with being discharged to home by himself. Resident #1 lacked community resources and a dedicated support network to provide at-home support and was without assistance except for a friend delivering a meal from the time the facility dropped him off until Adult Protective Services (APS) arrived in the evening of 2/27/24. APS contacted emergency transport services to send Resident #1 to the hospital emergency department. Upon admission, Resident #1 was noted with bedbugs, weakness, lower extremity edema and high blood pressure. Resident #1 described feeling worried, humiliated, isolated, and helpless.<br><br>Immediate jeopardy began on 2/27/24 when Resident #1 was discharged to his residence without caregiver support. The immediate jeopardy was removed on 03/22/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on | F 660 | the administrator or designee contacted all residents who were discharged home in the last 90 days to ensure they had access to their medications, equipment, home health, a working phone, and their activity of daily living care needs are being met. No other issues with those residents discharged home in the last 90 days were noted.<br><br>What will the facility do to prevent this from recurring:<br><br>On 3/19/2024 the regional director of clinical services provided education to the facility interdisciplinary team (IDT.) The IDT team consists of: Administrator, Director of Nursing, Social Worker, MDS Coordinators, Director of Rehab, Business Office Manager, Unit Manager, Dietary Manager, and Admissions Coordinator. The in-service content consisted of: Facility Discharge Planning Policy, the Progressive approach to home (PATH) program with the goal of preventing barriers to discharge home. Any newly hired member of the IDT team will be receive this same education during orientation. All licensed nurses, licensed therapist and certified nurse aides were educated to notify their supervisor if they identify barriers to discharging home. All newly hired licensed nurses, licensed therapist and certified nurse aides will receive the same education during orientation.<br><br>How will the facility monitor and maintain ongoing compliance: | |

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| F 660 | Continued From page 10<br>01/15/24 after a hospitalization for continuation of intravenous antibiotics for an infection following a surgical procedure.<br><br>Resident #1's care plan dated 01/16/24 revealed a focused area for discharge to the community, with a goal that the resident would have a safe discharge back to the community. Interventions for the focused area included to involve specialized home health care agencies, and appropriate community support services, provide resident and family with written instructions upon discharge, periodically reevaluate resident's capabilities to return to the community, and upon discharge resident and family will receive written discharge instructions to enable a safe return to the community.<br><br>A facility social worker (SW) progress notes dated 01/18/24 at 9:04 PM revealed a care plan meeting was held, and the resident's plan was to return home. The SW documented the Resident had not had home health in the past and had no equipment at home.<br><br>The admission Minimum Data Set (MDS) dated 01/21/24 revealed Resident #1 was cognitively intact with diagnoses that included infection following a procedure, hypertension, heart disease, muscle weakness, peripheral vascular disease, and presence of coronary angioplasty implant and graft (A stent graft is a small metal coil or mesh tube that is placed in an artery thickened with a buildup of plaque which has decreased the flow of blood and oxygen to the heart). The MDS indicated he had a discharge plan and the local contact agency had not been contacted. | F 660 | To monitor and maintain ongoing compliance beginning 3/25/24 the administrator or designee will review 5 discharge plan of cares to ensure the facility has implemented an effective discharge plan.<br><br>The administrator or designee will contact 5 residents/responsible parties after discharge to ensure the resident needs have been met and there are no issues with the discharge. Audits will continue for 12 weeks.<br><br>QAPI:<br><br>The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.<br><br>Results from audits will be brought to the monthly QAPI meeting x 3 months.<br><br>AOC Date : 4/9/24 | |

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A review of the SW progress notes revealed she documented that she issued four Notice of Medicare Non-Coverage (NOMNC) with the last dates of care as 02/05/24, 02/08/24, 02/18/24, and 02/22/24.

On 02/02/24 at 6:16 PM the SW documented that she and the Business Office Manager (BOM) spoke with the resident's family member. The family member stated he would not take the resident home to his house in his condition. The family member explained he could not take care of the resident. The SW documented the family member stated if the facility discharged the resident to his house, he would call adult protective services. The SW documented the resident was stand by assist (SBA) and contact guard assist (CGA - The person can do the transfer or self-care task with the caregiver providing a light touch (hence the term contact guard) for safety). The SW documented the resident was SBA to CGA in therapy as that time. The SW's note stated the resident's family member voiced he was going to do an appeal.

On 02/06/24 at 10:39 AM The SW documented a NOMNC was issued with the last covered day of 02/08/24. The note revealed the resident did not want to go back to his house due to it not being safe. The note further revealed the family member was in the process of trying to find a facility closer to him where they could take the resident. The SW documented Medicaid pending. On 02/15/24 at 4:09 PM the SW documented a NOMNC was issued with the last covered day of 02/18/24. The resident's family member was notified as well. The resident was given contact information to KEPRO, the organization responsible for beneficiary review and skilled

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service termination appeals and a copy of NOMNC as well.

On 02/20/24 at 12:53 PM the SW documented a NOMNC was issued with the last covered day of 02/22/24. The note read that the SW left a voicemail for the resident's family member. The note stated the resident, and his family member were informed that placement had not been found. The SW note further indicated the facilities she had contacted or left voicemails for the facility and the facility had declined admission, or she had not received a response from them. The SW note included she had given the resident and his family member information regarding the care patrol (a senior care advisory organization that help families find senior care solutions for their family member when living at home alone is no longer a safe option following hospitalization, a change in health, or due to the natural aging process) to help with placement.

A review of the Physician's Order written on 02/26/24 at 4:16 PM revealed Resident #1 was to be discharged on 02/27/24 with Physical Therapy/Occupational Therapy evaluation and therapy as indicated, Home Health Agency to help with personal care as needed, Skilled Nurse for medication management/wound care, and a Social Worker for possible treatments/needs.

On 02/26/24 at 5:08 PM the SW documented she received fax notification on the resident's reconsideration from KEPRO and the resident lost. The Resident was informed of this notification and was also told that starting on 02/23/24 he was considered as private pay. SW documented she called the resident's family member and his friend to inform them as well.

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The note revealed the resident, his family member, and his friend were aware he would be discharged on 02/27/24 with a transport time of 10:30 AM. The SW notes she spoke with the resident's friend about the copays that needed to be paid before his wheelchair and walker would be delivered. The note stated the friend voiced she would make the copay since she was the one who managed his money. The SW noted she would continue with discharge planning.
On 03/18/24 at 10:28 AM an interview was conducted with the Adult Protective Services (APS) SW #1. She stated APS had received a report of self-harm due to Resident #1 living in an unsafe dwelling prior to admission to the facility and the facility's plan to discharge the resident back to that environment. She was informed Resident #1 resided in the facility and she entered the facility on 02/09/24 at 3:15 PM. She stated she announced herself at the front desk and she was wearing her APS SW badge. She stated she went to the nurses station where there were multiple staff at the nurse's station and was pointed in the direction of Resident #1's room. She said Resident #1 told her he wanted to go to a long-term care facility near his family. He said they had been doing therapy on his legs and it was helping but he was still very weak. The APS SW #1 stated at that time Resident #1 did not have a set discharge date. She stated multiple attempts to inform the facility SW of the open APS case by phone and voice mail were unsuccessful. The APS SW had not visited Resident #1 in his home.

A review of the medication review report dated 02/26/24 at 4:25 PM revealed Resident #1 was prescribed the following medications upon discharge:

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-Acetaminophen ER Oral Tablet Extended Release 650 MG Give 1300 mg by mouth every 24 hours as needed for pain
- Albuterol Sulfate HFA Inhalation Aerosol Solution108 Oral (90 Base) MCG/ACT (Albuterol Sulfate) 2 puffs inhaled orally every 6 hours as needed for chronic obstructive pulmonary disease
- Amlodipine Besylate Oral Tablet 2.5 MG Give 1 tablet by mouth one time a day for hypertension
- Aspirin Oral Tablet Delayed Release 81 MG Give 81 mg by mouth one time a day for heart health
- Atorvastatin Calcium Oral Tablet 40 MG Give 40 mg by mouth at bedtime for hyperlipidemia
- Bisacodyl Suppository Insert 10 mg rectally as needed for constipation
- Docusate Sodium Oral Capsule 100 MG Give 1 capsule by mouth every 12 hours as needed for constipation
- Sodium Phosphates enema Insert 1 application rectally as needed for constipation
- Hydralazine HCl Oral Tablet 25 MG Give 25 mg by mouth three times a day for hypertension
- Lasix Oral Tablet 20 MG Give 1 tablet by mouth every 24 hours as needed for edema
- Metoprolol Succinate Oral Capsule ER 24 Hour Give 1 capsule by mouth one time a day for hypertension
- Milk of Magnesia Suspension 400 MG/5ML Give 2400 mg by mouth as needed for constipation
- Mirtazapine Oral Tablet 15 MG Give 15 mg by mouth at bedtime for sleep
- Omeprazole 20mg Capsule Give 1 capsule by mouth one time a day for gastroesophageal reflux disease
- Trazodone HCl Oral Tablet 100 MG Give 100 mg by mouth at bedtime for sleep

On 02/26/24 at 5:36 PM the SW's Social Service

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Summary revealed the resident was discharged in stable condition with home health and his primary care physician follow-up appointment was scheduled for 03/06/24 at 2:00 PM. The note indicated the resident was also set up with a social worker through home health to be able to help him at home with further services.

Resident #1's Discharge Instruction Form dated 02/26/24 at 5:36 PM indicated in Section II under the Pharmacy heading written prescriptions were provided to the Resident, no prescriptions were called in to a pharmacy. Additionally, under the Nursing heading Resident #1 had a bilateral groin wound which required a dry dressing. The Therapy heading of the Discharge Instruction Form revealed a home evaluation was not completed and a wheelchair and walker were ordered by the SW. The Rehab heading indicated Resident #1 needed continued therapy with bathing, dressing, toileting, transfers, and stairs.

On 02/27/24 at 3:00 AM Physician's Assistant Note read the resident was seen for their discharge summary. The note revealed the resident had remained at the facility since 1/15/24 and appealed discharge several times. He received and completed intravenous antibiotics for a groin infection. The resident was followed by infectious disease. His pain control continued to be an ongoing issue, but narcotics had been able to be deescalated to a non-narcotic pain reliever. The note further revealed Resident #1 received physical therapy and occupational therapy. He continued to have concerns about functioning at home on his own but would have his brother and home health.

On 03/17/24 at 1:40 PM an interview was

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conducted with the Director of Therapy, and she stated Resident #1 often verbalized to her he wanted to go back to his own home, and he had a neighbor friend who helped him out. The Resident's family member was made aware of his wish to return to his own home. She further stated Resident #1 was alert and oriented and was his own responsible person. She stated Resident #1's family member voiced concerns about the resident's safety and was interested in taking resident to his house. She stated she offered opportunities to train the family on assisting the Resident with hygiene care since Resident #1 did need some assistance with bathing and hygiene after toileting. She stated the family declined and told her they were not skilled to provide that level of care to Resident #1. She stated she told the family member home health would be available for the first couple weeks after discharge. The Director of Therapy stated the Resident was able to walk with a walker independently and transfer independently. She stated it was very difficult to get the resident and the family member to commit to a discharge plan because of their wish to appeal the discharge. They won several appeals but when their last appeal was denied. The facility offered Resident #1 a private pay room, but the Resident declined and said he was going to go back to his own home. She stated she did not conduct a home assessment.

On 03/18/24 at 4:51 PM an interview was conducted with Resident #1's family member and he stated the Resident had been admitted to the facility after having a couple of surgeries on his legs which had become infected. He stated he tried to get the Business Office Manager to help file for Medicaid and she said, "Oh, we can't do that" and the Social Worker said she could not

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help either. He stated Resident #1 was discharged from the facility to home and unfortunately, he was living in a terrible living environment. The family member stated Resident#1's home environment was not good due to rotting floors, holes in the floor, and an infestation of bed bugs. He stated Resident #1's trailer was falling apart. He stated that he thinks Resident #1's wounds initially got infected because of the bed bugs. The family member said that is why the Resident went back to the hospital and was then admitted to the facility. He added that before Resident #1 went to the hospital he had fallen and was unable to get up for a couple of days. The family member said Resident #1 was in the hospital for 34 days. He stated Resident #1 had an infection in his blood and they started him on intravenous antibiotics. The family member said Resident #1 was sent to the facility to finish his antibiotic regimen and for physical therapy and occupational therapy. He stated when he was discharged from the hospital, the hospital only requested rehabilitation to Medicare for the 23 remaining days and his antibiotics were not considered rehab. The family member said he repeatedly appealed each time the facility tried to discharge Resident #1. He said he ran out of appeals at the 4th level, but it did gain the Resident about two more weeks of therapy. Resident #1's family member stated that the Resident was up walking with a walker with the help of PT. The family member stated Resident #1 could not change his own brief when he was incontinent. The family member stated he was out of town when the resident received the third discharge notice, and they discharged Resident #1 home. The family member stated that resident #1 told the facility that his home was unsafe for him, and he told them he did not want

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to go there. The family member stated that facility staff transported Resident #1 to his home, wheeled him into home. set him on the couch, and just left him there. He stated Resident #1 was unable to get up and go to the bathroom, unable to prepare a meal for himself, and could not make any phone calls. The family member stated Resident #1's phone had started malfunctioning while he was hospitalized and had stopped working completely by the time he was admitted to the facility. He stated Resident #1 used the facility phone when he wanted to make a call. The family member stated a neighbor called him and told him Resident #1 had been dropped off at his home and had not been able to get up off the couch. He stated he told the neighbor to call APS for assistance. He stated APS tried to find Resident #1 emergency placement in a safe environment but there were none available, so she called an ambulance to take him to the hospital. He stated the resident was covered in bed bugs again. He stated the facility should never have dropped his brother off at his home. It was not a safe discharge to take him to his home. He stated Resident #1 said he had had his brief changed that morning but by the time he got to the hospital he had urinated in that brief about six times.

On 03/18/24 at 5:10 PM an interview was conducted with Resident #1's friend who was also his neighbor in the mobile home park. She stated she visited the Resident about every week. She stated on 02/05/24 she fell and could not visit the resident as often. She said she went to a care plan meeting in February for Resident #1 to talk about his discharge plan. She stated an appeal was filed because they were going to send him to an unsafe home. She stated at that discharge

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care plan meeting she told them the resident had nowhere to go because his home was not safe. She said she showed the SW pictures of the condition of the home. She stated there were holes in the floor, black mold in the bathroom and the ceiling was falling down in the bathroom. She said she told the SW Resident #1 couldn't go to his family member's home because he said Resident #1 had to be self-sufficient and the SW said "Well, we'll have to discharge him back to his own home then." The friend stated she informed the SW that she nor the Resident's family member would provide transportation back home for Resident #1. She stated they left him on his couch, unable to get up and walk for himself, go to the bathroom or anything else. She added that unfortunately, when she turned the heat back on and the place heated up, the bed bugs came out. She stated he sat on the couch, unable to get up, and covered in bed bugs. She stated she took him a plate of food that evening. The friend stated, "I was hot when I saw him sitting there, even with a walker he couldn't have maneuvered in there the way the floors were rotted out and the boards on the floor." She stated Resident #1's trailer park manager came to visit him in hospital, and the Resident signed his trailer over to him. She stated Resident #1 did not have a home phone and his cell phone had not worked since he was admitted to the hospital in December.

An interview was conducted on 3/17/24 at 1:03 PM with the Administrator and she stated Resident #1 was able to transfer and walk independently with wheelchair. She stated he had been admitted to the facility for short term rehabilitation due to a wound that required intravenous antibiotics through a peripherally inserted central catheter (PICC line). A PICC line

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is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. She further stated Resident #1 was only supposed to be in the facility for the duration of the antibiotic therapy. The Administrator explained Resident #1 filed an appeal for each NOMNC he received to the higher level until it was denied for the last time. She added Resident #1 had no skilled needs and was given a 30-day notice. The Administrator stated Resident #1's family member initially said they were willing to allow the Resident to discharge to their home. The Administrator stated later the family member changed his mind and said the Resident could not discharge to their home because Resident #1 required assistance with hygiene. The Administrator stated she told the SW they needed to talk to the Ombudsman to make sure they were doing the right thing. The Administrator relayed the Ombudsman confirmed discharging the resident home was appropriate. She stated the Ombudsman said the facility was not responsible for repairing the Resident's home if that was the condition it was in prior to his admission. The Administrator said it was explained to Resident #1's family that he would have home health services when he was discharged. She added referrals were made to other facilities, but they declined Resident #1 due to his payor source. The Administrator stated a home assessment and review for barriers to a successful discharge was not conducted. The Administrator stated they felt the need to contact the Ombudsman because the SW had put so much time and effort into researching available resources for this resident. She said the Ombudsman told the SW that the resident is alert and oriented and the facility is not a prison. The Administrator stated Resident #1, or his family

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member never voiced concerns that the Resident's house was not safe to live in or that there was any type of insect infestation.

Record review revealed no evidence a 30-day discharge notice was issued.

An interview was conducted with the Transportation Aide on 03/17/24 at 1:30 PM and she stated she had only transported one resident into their home and that was Resident #1 02/27/24 at 10:45 AM. She further stated she was accompanied by Nurse #1. She explained she wheeled Resident #1 up the ramp in a facility wheelchair and through the unlocked door of his mobile home. She said the living room was at the entrance and Resident #1 transferred himself independently from the wheelchair onto the couch. She stated she folded the wheelchair up and pushed it out the door. She added the nurse who had accompanied her in the transportation van brought two boxes of Resident #1's personal items into the home. She stated the Resident asked the nurse to set one box on the television tray table by couch and one on the island between the living room and kitchen. She stated she did not go any further beyond the living room into the home. She stated his phone was on the table beside him and she thought it worked. She further stated it was not plugged into a charger.

An interview was conducted on 03/17/24 at 2:10 PM with Nurse #1 who accompanied the Transportation Aide during Resident #1's discharge home. She stated the Transportation Aide pushed Resident #1 up the ramp in a wheelchair and went in the unlocked mobile home. She stated Resident #1 transferred himself from the wheelchair to the couch. Nurse #1

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explained she brought in two boxes of the Resident's belongings. She said he asked to place the box that contained soft drinks on the table beside him and told her to place the other box on the counter between the kitchen and living room. She stated the box which she put on the counter contained his written prescriptions. Nurse #1 added the trailer was warm, cluttered, and smelled of old cigarette smoke. She added as she walked from the living room to the kitchen counter, she did not feel any weak spots or holes in the floor. She stated she did not see any rodents or insects. Nurse #1 said Resident took his cell phone from his pocket and put it on the tray table. She stated she assumed the phone worked but did not check it and did not see a charging cord. Nurse #1 added while in the facility she observed Resident #1 ambulate with a walker and a wheelchair. She stated he only needed some assistance with hygiene. She did not observe Resident #1 get up and ambulate after he sat down on the couch.

On 3/17/24 at 4:26 PM an interview was conducted with the facility Social Worker, and she stated Resident #1's discharge process began on his admission to the facility. She explained a form called Your Path was used which allowed for input from the Minimum Data Sets (MDS) Nurse, Therapy, Nursing, SW and Business Office Manager input. Each discipline had a piece of the Your Path form to fill out that assessed the Resident's needs so they could be addressed. She stated the Your Path form provided a baseline to work from. Nursing for education, Therapy for physical/occupational needs and for SW to know where the resident came from, where he planned to discharge to and any equipment or services he may need. She

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explained Resident #1 was ordered home health, physical and occupational therapy, a home health aide, and skilled nursing for medication management. She stated home health usually visited within 24 to 48 hours after discharge. The SW stated the only concern voiced about the Resident #1's home environment was from the Resident's family member who said the floor had areas without carpet. She stated on 02/06/24 she called the Ombudsman to make sure the facility was doing the right thing because Resident #1's family member was concerned about the flooring in Resident #1's home. The SW stated the Ombudsman told her if the Resident lived in his home prior to admission then could be discharged back to his home from the facility. The SW added the Ombudsman stated it was not the facility's responsibility to fix anything that was wrong with Resident#1's home. The SW stated the Ombudsman said if the facility set up Resident #1 with a home health aide, a skilled nurse and a social worker, discharge was appropriate. The SW stated Resident #1's neighbor told her she would be responsible for getting Resident #1's prescriptions filled and assisting him in his home. She stated the Home Health Agency would provide a Home Health Aide to assist Resident #1 with his needs for a period of time. The SW stated she would not send a resident to an unsafe environment and that is why she called the Ombudsman for clarification.

On 03/18/24 at 9:15 AM an interview was conducted with the Ombudsman, and she stated the facility SW said Resident #1's family member had said he was going to take the Resident home with them but then declined. The Ombudsman stated the SW said that Resident #1's family member had voiced concerns regarding the

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flooring in the Resident's home. The Ombudsman said she spoke with her colleagues, and they advised that if the Resident's home was in the condition he left it then he could return to it. She stated she relayed that information to the facility social worker. She stated she told the SW that if the Resident was to be discharged back to his home, to make sure he had home health services and a social worker.

An interview was conducted on 03/18/24 at 7:34 AM with the Home Health Nurse and she stated she received the referral for Resident #1 on 02/27/24. She explained she called his number on the evening of 02/27/24 to set up a time to visit him. She stated the phone number did not work. She said she tried the family member's and friend's number listed in his file and didn't get an answer, so she went out on 02/28/24 to check on the Resident. She said she drove out to his house and knocked for several minutes and couldn't get an answer. She stated she was able to finally reach Resident #1's friend by telephone who informed her Adult Protective Services had been called the evening prior and the Resident was sent by ambulance to the hospital.

On 03/18/24 at 10:39 AM an interview was conducted with the APS SW #2, and she stated she called the facility SW on 02/27/24 and did not get an answer, left a voicemail but did not receive a call back from the SW. She stated she called and spoke with Resident #1's family member on the 2/27/24. She stated the family member was very frustrated with the facility. She said Resident #1's family member had filed an appeal three times and it had been approved those three times for the Resident to have an extended stay for therapy. He said that the facility told him Resident

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#1 needed an assisted living level of care. The APS SW #2 stated the Resident's family member told her Resident #1 was unable to use a wheelchair or walker due to his physical limitations and the poor condition of his home. The family member told APS SW #2 the Resident was incontinent and he needed help with dressing, bathing, grooming, meal prep, and medication assistance. He reported to the APS SW #2 that the facility said Resident #1 needed 24-hour care however there's no one in Resident #1's home to provide that care. The APS SW #2 stated she called the facility SW multiple times and left multiple messages which were unanswered.

An interview was conducted with Resident #1 on 03/18/24 at 10:45 AM from his hospital room phone and he stated he was at the facility on 1/15/24 to continue antibiotic therapy for a wound he had. He stated he also received PT and OT. He stated that the final appeal was not granted, and he was going to be discharged. He stated he told the facility SW his house was not safe. He stated he told them that the floors had holes in them and that it was infested with bedbugs. He stated after being in the hospital for a month in December 2023 his health had declined, and his muscles had weakened to the point he needed physical therapy at the nursing home to help him get enough strength back to walk with a walker. He stated prior to going in the hospital in December he could walk to the store, or his friend would take him to get whatever he needed from town. He stated they told him that if he stayed at the facility, he would be private pay. Resident #1 stated he could not afford $500 a day so he felt his only choice was to be discharged back to his unsafe home. He stated he did not apply for

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Medicaid in the facility. Resident #1 said the facility transportation aide and a nurse took him to his house, they rolled him up the wheelchair ramp into the house and he transferred himself onto the couch. He stated the nurse put a box of soft drinks next to him on the table and a box with his prescriptions in it on the island between the kitchen and living room. Resident #1 stated he urinated on himself about six times because he could not pull himself up to the walker to go to the bathroom. He stated he did not have a working phone to call anyone to help him. He stated he felt worried, humiliated, isolated, and helpless. Resident #1 stated his neighbor stopped by to visit him, saw the condition he was left in and called his family member. She called APS and they came to his home and sent him to the hospital. Resident stated he was unable to call anyone because his phone had not worked since his admission to the hospital in December. He added when he wanted to make a phone call he used the room phone.

On 03/18/24 at 12:22 PM an interview was conducted with APS SW #3, and she stated APS received a phone call on 2/27/24 at 4:45 PM Related to Resident #1 discharge to an unsafe home. She stated the call was from a neighbor who was very concerned about Resident #1 being left alone in an unsafe home. She stated she walked into the house, and he was sitting on his couch by the door with a plate of food that his neighbor had brought him. She stated she asked him if he could get up and he said he wasn't able to stand on his own. She stated she asked him if he felt safe in his home, and he stated he did not feel safe in his home. She said she asked if he had moved since he had been dropped off at his home and he stated he was not able to move

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from the couch on his own. She stated she asked him how he had been going to the bathroom and he said that he had on an adult diaper the whole time and he had used it three or four times. Resident #1 also advised the APS SW #3 that there had been no one at the home to help him until the friend came by to check on him. APS SW #3 stated that Resident #1 had hundreds of bed bugs crawling on him. She stated they were very visible, and he was spraying some kind of chemical on him every time one would bite him. She stated the mobile home had a horrible smell of chemicals related to Resident #1 spraying himself. She stated his walker was in reach, but he was unable to stand to use it. She stated there was a wheelchair on the other side of the room folded closed. She stated she called the emergency medical services (EMS) to transport Resident #1 to the hospital. She said the EMS team had to assist Resident #1 to stand because his legs were "like wobbly sticks". The APS SW #3 had Resident #1 transported to the hospital by (EMS) for evaluation. The neighbor stated Resident #1 had a cell phone, but it had not worked since he had been admitted to the hospital in December. She stated he kept the phone in hope that it would start working again.

On 03/18/24 at 1:37 PM an interview was conducted with the Certified Occupational Therapy Assistant (COTA) and she stated Resident#1 was able to transfer from wheelchair to bed and back with minimal assistance for balance. She further stated Resident #1was not safe for toileting without minimal assistance due to unsafe balance. She added he displayed a loss of balance with supine to sit. She explained it was unlikely Resident #1 could function independently due to balance concerns and he needed 75%

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verbal cues for sequencing during dressing.

An interview was conducted with the Occupational Therapist (OT) on 03/18/24 at 2:07 PM. She stated Resident #1 was very slow, at times was agitated and noncompliant. She further stated Resident #1 could not toilet independently because he wouldn't wipe himself because it was difficult due to his groin wounds. She said the wounds were healed but he still didn't want to wipe himself. The OT added she did not think Resident #1 would be safe to live independently because he still required minimum assistance. She stated Resident #1 told her his house wasn't safe because he had holes in the floor and wouldn't be able to use a wheelchair.
The Emergency Medical Services (EMS) report dated 2/27/24 revealed they were dispatched at 8:00 PM for a welfare check. They arrived at Resident #1's home at 9:34 PM and found "Patient had bedbugs crawling on his skin from head to toe." He was unable to stand or walk without assistance. Resident #1 was assisted to a stretcher by two Emergency Medical Technicians and transported to the hospital for evaluation.

The hospital emergency room record dated 2/27/24 revealed patient presented with bedbugs on arrival. Resident #1 reported he could not care for himself and became too weak to ambulate on his own or to use his walker or wheelchair. He was noted to have bilateral lower extremity edema, blood pressure was 213/85. Resident #1's lab values revealed his white blood cell count was 2.4 per microliter, the normal range is 4.5-11.0 per microliter. His hemoglobin was 10.6* grams per deciliter, the normal range is 14.0-18.0 grams per deciliter. Resident #1's hematocrit was 33.3% the normal range is 40 -

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54%.

The Administrator was notified of immediate jeopardy on 3/19/24 at 6:00 PM.

The facility provided a credible allegation of immediate jeopardy removal on 3/23/24 as follows:

-Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Resident #1 was discharged to home on 2/27/24. The resident went sent home with no confirmed support system that would have been able to obtain the resident's prescription medications and provide the resident assistance with his activities of daily living such as bathing, transfers, toileting, peri-care, and meal preparation. The facility had not confirmed the resident had a working phone for emergencies. The facility failed to have a plan to provide the resident assistance with his care for the length of time between discharge and the arrival of the home health staff the day after discharge. The facility failed to have an acceptable plan prepared for Resident #1's discharge. Resident #1 was discharged to unsafe situation on 2/27/24. The Transportation Aide and the Unit Supervisor went with Resident #1 to into his home, the resident transferred to his couch, and the Transportation Aide and the Unit Supervisor left Resident #1's home without immediate on-site assistance. Resident #1's friend went to resident's home later that day to check on resident. The friend called the resident's family member to advise him of Resident #1's condition. The family member instructed the friend to call the Department of Social Services Adult Protective Services (APS). The APS Social

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Worker went to resident's home on 2/27/24. The Social Worker reported that the resident told her that he had been sitting on his couch and had incontinent episodes from the time the facility staff had transported him home. Resident #1 told the Social Worker he had been unable to care for himself due to not being able stand up from his sitting position on the couch. He also advised the Social Worker that there had been no one at the home to help him until the friend came by to check on him. The Social Worker had Resident #1 transported to the hospital by Emergency Medical Services (EMS) for evaluation. When Resident #1 arrived at the hospital his blood pressure was noted to be 213/85. The resident is currently in the hospital. Resident #1 is scheduled to return to the facility on 3/22/24. The facility does not have any certified beds available until this date.

-All residents discharging home have the potential to be affected.
On 3/19/2024 the facility Social Services Director, Director of Rehab, Administrator, Unit Manager, Admissions Coordinator, Business Office Manager, and Dietary Manager reviewed all residents that were discharged home during the last 90 days and also called and spoke to the residents or the resident's responsible parties to ensure the resident had access to their medications, any ordered adaptive equipment had been delivered, any ordered home health services had been initiated, how the resident's activity of daily living needs were being met, that included bathing, transfers, toileting, peri-care, and meal preparation. Any questions were answered. No concerns were identified.

-Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
On 3/19/2024 the regional director of clinical services provided education to the facility interdisciplinary team (IDT.) The IDT team consists of: Administrator, Director of Nursing, Social Worker, MDS Coordinators, Director of Rehab, Business Office Manager, Unit Manager, Dietary Manager, and Admissions Coordinator. The in-service content consisted of: Facility Discharge Planning Policy, the Progressive approach to home (PATH) program to include developing a and implementing an effective discharge plan to include planning for access to medications, assistance in the home for basic Activities of Daily Living (ADLs) such as transfer from the couch to a wheelchair, toileting, peri-care, meal preparation, and bathing. The IDT team were educated on beginning the resident's discharge planning on admission that includes a 72- hour care plan meeting with the resident/and or resident's responsible party. The facility will use the PATH meeting template to discuss the residents' diagnoses, medications, pain, oxygen, skin integrity, fall/safety, continence and peri care needs, cognitive/communication, mood/behavior, ambulation/strength, self-care, the need for a home visit, barriers to returning home, working phone, nutritional needs, community support, equipment needs, education needs, pharmacy used by resident, how resident and (or) responsible party will be able to obtain medications-by either having written prescriptions or medications called into the pharmacy. The Director of Nursing and/or designee will ensure that the resident has a supply of medications sent home with that resident if there is an overlap time with the resident and/or responsible party being

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able to obtain their medications. The business office manager was educated to meet with each resident/and or resident's responsible party during the 72-hour care plan meeting that has been set up to discuss co-payment information, and options for private pay and/or Medicaid. If the resident/and or resident's responsible party asks to apply for Medicaid, then the business office manager will assist in that process. The facility will have the resident and/or responsible party sign the PATH form to confirm all areas were discussed. The IDT team was educated to utilize the PATH progress report to update the resident and/or responsible party weekly on the resident's progress towards reaching their goals for discharge. The PATH progress note includes assistive devices used, toileting needs, bathing needs, dressing needs, transfer status, and education provided. When a pending discharge for a resident is noted, the social worker will notify the resident and/or responsible party of the estimated discharge date and that the resident discharge goals are the same or if there is a need for modification. The IDT will meet to review the discharge plan of care and ensure that each part discussed in the PATH meeting template has been addressed, to include gaps in care until home health arrives. The social worker will meet with the resident/and or responsible party to discuss the discharge plan and have the resident/responsible party sign the PATH meeting template again with the new added information for discharge, and a copy is given to the resident/responsible party. Nursing will meet with the resident and/or responsible party prior to the resident's discharge to review the resident's medications and plan for how resident will obtain medications. The social worker will educate the resident/responsible party that when the resident

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is discharged home if they encounter any issues, they need to communicate those issues to the home health staff or call the facility for assistance. Prior to discharge the facility will ask the resident/responsible party if they have a working phone or a system in place for emergencies. The IDT team was educated that on the day of discharge the resident/responsible party will be provided with discharge instructions that includes discharge plans and opportunity for the resident and/or responsible party to ask questions before signing the discharge instructions. The social worker was educated to set up a Primary Care Provider (PCP) appointment within 5 days of discharge or first available. The social worker was also educated on calling the resident/responsible party within 24 hours of discharge to verify they have access to their medications, home health has been initiated, any ordered equipment has been delivered, ADL needs are being met, and if there are any questions or concerns. Any newly hired member of the IDT team will be in-serviced during orientation.
All licensed nurses, licensed therapists, and certified nurse aides were educated 3/21/2024 by the administrator, unit manager, and director of rehab. The education consisted of: resident's discharge goals and estimated discharge date will be added to the resident's care plan or Kardex, if the staff identifies that the resident has not reached their goals by discharge or there are any concerns with that resident they are to report issues to their supervisor (Unit Manager/DON/Assistant Director of Nursing/Director of Rehab), if the resident is to deemed to be independent with ADLs at discharge and the staff is still providing and charting hands on care and charting hands on care the staff member should report this to their

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supervisor. The supervisor will report concerns to the IDT team for review. Any staff out of work for Family Medical Leave Act (FMLA), vacation, and out sick will be in-serviced on before they return to work. Any newly hired nursing member will be in-serviced during orientation.
On 3/19/2024, the IDT team reviewed all of the known upcoming planned residents' discharges. The PATH meeting template that had been completed in the 72 hour meeting was reviewed by the IDT to include discuss diagnosis, medications, pain, oxygen, skin integrity, fall/safety, continence and peri care needs, cognitive/communication, mood/behavior, ambulation/strength, self-care, the need for a home visit, barriers to returning home, nutritional needs, community support, equipment needs, education needs, pharmacy and a plan to obtain medications, primary care provider appointment. The facility reviewed and implemented interventions for gaps in care until home health is implemented. One resident was identified as not meeting the criteria for discharge home. The insurance company was contacted, and the facility was able to obtain a 7-day extension. Resident/responsible party were offered to meet with the business office to discuss payment options to include applying for Medicaid if they wish to remain in the facility. The PATH note was reviewed with the resident/responsible party and signed to validate final discharge care plans. The IDT team is responsible for establishing residents' discharge plans of care. The facility social worker is responsible for discharge coordination.

The Administrator is responsible for the credible allegation.

Alleged date of IJ removal 3/22/24.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345381 | A. BUILDING _____ B. WING _____ | C 03/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VILLAGE CARE OF KING | 440 INGRAM ROAD KING, NC 27021 |

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| F 660 | Continued From page 35<br><br>The credible allegation removal was verified on 03/23/24 as evidenced by the following verification of re-education for licensed nurses of documentation for discharge of a resident including assessment, discharge summary, medication release form and discharge instructions, validating the SW was reviewing resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge, education to the Administrator, Director of Nursing, Social Worker, MDS Coordinators, Director of Rehab, Business Office Manager, Unit Manager, Dietary Manager, and Admissions Coordinator by the regional director of clinical services regarding safe and orderly discharges for residents being given a 30-day discharge notice including documentation of discharge preparations, barriers, and resident status. Interviews with nurses, nurse aides, and therapy department staff revealed they had received training that if they identified that a resident had not reached their goals by discharge or there were any concerns with a resident they were to any concerns to their supervisor. They received education to report if a resident still required hands on care when discharge date was near.<br><br>The immediate jeopary was removed on 03/22/24. | F 660 | | |
| F 661 SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, | F 661 | | 4/9/24 |

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| F 661 | Continued From page 36<br>but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review, the facility failed to complete a discharge summary for 1 of 1 resident (Resident #1) reviewed for planned discharge to the community.<br><br>Findings included:<br>Resident #1 was admitted to the facility on 01/15/24 with diagnoses that included, in part, infection following a procedure, hypertension, heart disease, muscle weakness, and peripheral vascular disease. | F 661 | The facility failed to provide resident #1 with a written discharges summary when he was discharged home.<br><br>Corrective action for affected resident:<br><br>Resident #1 readmitted to the facility on 3/25/24.<br><br>How will the facility identify other like residents: | |

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| F 661 | Continued From page 37<br>A review of the comprehensive Minimum Data Set (MDS) assessment dated 01/21/24 revealed Resident #1 was cognitively intact and discharge planning was in place as Resident #1 expected to be discharged to the community.<br><br>A review of the medical record revealed a discharge instruction sheet dated 02/26/24 was provided to the resident on the day of discharge. The discharge instruction sheet included information on home health services and a list of medications.<br><br>A review of the medical record revealed no discharge summary was completed prior to or after Resident #1 discharged home.<br><br>Resident #1's care plan dated 01/16/24 revealed a focused area for discharge to the community, with a goal that the resident would have a safe discharge back to the community. Interventions for the focused area included to involve specialized home health care agencies, and appropriate community support services, provide resident and family with written instructions upon discharge, periodically reevaluate resident's capabilities to return to the community, and upon discharge resident and family will receive written discharge instructions to enable a safe return to the community.<br><br>Resident #1 discharged home on 02/27/24.<br><br>On 03/19/24 at 4:05 PM an interview was completed with the Administrator. She stated she was not aware Resident #1 had requested assistance with Medicaid to remain in the facility. She stated she thought he wanted to apply for community Medicaid because he wanted to go | F 661 | To identify other residents that have the potential to be affected, on 4/9/24 the Administrator or designee reviewed resident records for the last 30 days for the discharged summary being provided to the resident upon discharge home.<br><br>What will the facility do to prevent this from recurring:<br><br>To prevent this from recurring on 3/19/24, the Regional Director of Clinical Services educated the interdisciplinary team to include, the social worker, therapy director, director of nursing, assistant director of nursing, unit managers, dietary manager, and administrator on completing a discharge summary per company policy. On 4/9/24 all licensed nurses were educated by the administrator or designee to review the discharge summary with the resident/responsible party upon discharge, and provide them a copy of the discharge summary. All newly hired licensed nurse and interdisciplinary team members will receive this same training during orientation.<br><br>How will you monitor and maintain ongoing compliance:<br><br>To monitor and maintain ongoing compliance beginning 4/10/24 the administrator or designee will audit 5 resident records per week to ensure that the resident was provided a discharge summary upon discharge home. Audits will continue for 12 weeks | |

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| F 661 | Continued From page 38<br>home. She stated discharge instructions were provided. She was not aware the Resident did not receive a discharge summary. She stated a discharge summary should have been sent with resident. | F 661 | QAPI:<br><br>The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.<br><br>Results from audits will be brought to the monthly QAPI meeting x 3 months.<br><br>AOC 4/9/24 | |