STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049030	A. BUILDING: _____ B. WING _____	C 09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted a complaint investigation on August 31, 2015 and September 1, 2015. The complaint investigation was initated by the Iredell County Department of Social Services on August 19, 2015.	D 000		
D 226	10A NCAC 13F .0702(b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the reason of discharge of 1 of 5 sampled residents (Resident #1) was	D 226		

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D 226	Continued From page 1 justified. The findings are: Review of the facility's "Adult Care Home Notice of Transfer/Discharge" dated 8/7/15 revealed: -The selected reason for the notice was identified as "The safety of the resident or other individuals in the facility is endangered." -Under "Notification", the facility reported the Power of Attorney (POA) was notified. -The planned discharge location was a nearby Behavioral Health Center where the resident was currently being treated. -The facility documented the option of "The facility has convened the adult care home resident discharge team." -Additional documentation in the right margin of the Discharge Notice revealed the no box was checked and circled regarding the adult care home resident discharge team with notation "per DSS cty [county] monitor [name inserted] and dated 8/10/15 -The discharge notice was accompanied by the "Adult Care Home Hearing Request Form." -The notice of discharge was signed by the Administrator on 8/7/15. Interview with the resident's two POAs on 8/31/15 at 8:50 pm revealed: -Resident #1 was currently receiving treatment in a nearby Behavioral Health Center (BHC) since 7/20/15. -The POAs reported the discharge planner from the BHC had contacted the facility and the POAs for discharge planning as the resident was ready to return to the facility the week of 8/10/15. -The POAs had taken the resident to her treating mental health provider on 7/17/15 for a routinely scheduled office visit.	D 226		

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-The POAs reported to the doctor they were concerned regarding her increased paranoid symptoms in spite of the gradual medication adjustments the doctor had been making.
-The POAs stated the doctor had been adjusting the resident's medications but was not getting the results he had wanted.
-The doctor chose to admit Resident #1 for in-patient treatment to provide a safer environment for medication adjustment.
-The POAs stated the resident had three other hospitalizations in the past 2-1/2 years for medications adjustment and intensive therapy, the last being 8/24/14.
-The POAs stated they were told by the Administrator after the hospitalization discharge of 8/29/14 that if Resident #1 had another in-patient stay, she would issue a discharge; "no reason was given."

Review of the Resident Register revealed Resident #1 was admitted to the facility on 1/13/11.

Review of Resident #1's current FL-2 signed on 8/28/14, which was from the hospital discharge of 8/29/14, revealed:
-Diagnoses included Schizoaffective Disorder.
-Mood Indicators-Behavioral Symptoms under Section II documented she was not a wanderer, not verbally abusive, not physically abusive and not dangerous to self, others or property.
-The resident was assessed as needing limited assistance for bathing and dressing and prompting at time.

Review of the hospital discharge summary dated 8/29/14 revealed:
-She was discharged back to the assisted living facility she had been residing in before admission

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to the hospital.
-There was documentation of some symptoms of "religious preoccupations" but were "minimal compared to admission.
-Upon admission to the hospital she was reported to have tried to escape from the facility and was hearing voices telling her to kill herself and to harm others.

Further review of the resident record revealed there was no facility discharge intention documented associated with the 8/29/14 hospital stay, before or after that date until 8/7/15.

Review of the facility's "Nurse's Notes" from 2/12/15 through 7/17/15 revealed:
-There were numerous events of the resident "yelling" at staff, mostly related to medication administration and having to wait for her medications.
-There were numerous events of resident agitation.
-Several instances of medication refusal for bowel regularity and functioning.
-On 5/9/15, Staff documented the resident thought someone "keeps sitting in her room."
-On 6/4/15, the resident told staff she was "in love with the doctor" at the facility and "makes me sad I can't be with him."
-On 6/18/15, the resident reported to staff "someone by the name of Jeff was in her room."
-On 6/22/15, the resident complained of "other people sitting in her front area." [It was explained to the resident another resident was moved into the second bedroom of the suite.]
-On 6/24/15, the resident reported to staff "Jeff was here today." The resident became agitated and told staff "she better stop messing with her and playing games because you know exactly who Jeff is."

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-On 6/25/15 and 6/27/15, the resident complained to staff that they were turning off her air conditioning and thermostat to make it warm in her room.
-There was no documentation the resident's mental health provider was notified during 2/12/15 through 7/17/15.

Review of the office notes and reports of doctor visits revealed:
-On 7/17/15, the resident reported to the doctor hearing voices and seeing "Jeff" and that "Jeff will murder her." He increased her medications and wanted to consider hospitalization.
-On 6/19/15, the doctor spoke via phone to the POAs regarding the resident's delusions and hallucinations and adjusted her medication.
-On 5/8/15, the resident reported no hallucinations, mood was stable with no suicidal/homicidal ideations. No change to medications.
-On 3/13/15, the resident was calm during the interview but family reports some aggression especially when medications are wearing off. Medications were adjusted and new medication was added.
-On 1/30/15, the resident reported auditory hallucinations at times with none commanding her to harm self or others. Medications changed and added.

Attempted telephone interview with the treating psychiatrist on 8/31/15 and 9/1/15 revealed the telephone numbers were no longer in use.

Interview with the Administrator on 9/1/15 at 8:00 am revealed;
-She had been the Administrator for approximately 2 years.
-She stated Resident #1 became more withdrawn

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prior to her regular appointment with the doctor but she did not notify the doctor.
-The Administrator was not afraid of Resident #1 and was not aware of any resident to staff or resident to resident physical contact recently.
-There were two care plan meetings with the POAs, but no extra staff meeting to address any behavior Resident #1 was exhibiting during the last several months prior to hospitalization.
-She stated she wrote the discharge notice after the review of the hospital notes forwarded on 8/5/15.
-She stated according to the notes, Resident #1 was still having delusions regarding someone trying to kill her.
-The Administrator did not speak with the mental health provider at the BHC regarding Resident #1's current mental health status prior to issuing discharge notice.
-The Administrator stated the facility's RN went to the BHC on 8/10/15 or 8/11/15 to assess the resident.
-It was a collaborative corporate decision to delivery a notice of discharge on 8/7/15.

Interview with the facility's RN on 9/1/15 at 9:15 am revealed:
-The RN received a call from the BHC requesting discharge back to the facility on 8/4/15 or 8/515.
-The RN could not go to the BHC until 8/11/15 for assessment.
-She stated the discharge notice was written on 8/7/15 after review the notes provided by the BHC which alluded to the resident still having delusions and was a danger to self.
-When the RN completed her onsite assessment at the BHC, she did not speak with the mental health provider or the therapist regarding Resident #1's current mental health on 8/11/15.
-The RN felt the resident was still paranoid.

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-The RN did not believe Resident #1's behavior was worse this hospitalization versus the hospitalization of 8/29/14.
-The RN stated she was not fearful of Resident #1, but feared for her staff.
-The RN stated Staff had reported to her Resident #1 had "shook a finger at a medication aide's face and very nearly touched her nose" in July 2015.

Interview with the BHC mental health provider/Nurse Practitioner (NP) on 9/1/15 at 1:57 pm revealed:
-The NP stated Resident #1 was ready to return to her home [the facility].
-The NP stated Resident #1 was not a danger to self and is appropriate for assisted living.
-The NP reported having sent a note to the facility on 8/10/15 stating Resident #1 was not a danger to self and was appropriate for assisted living.
-The NP stated the software they use for electronic notes sometimes carried comments over from previous notes, but that Resident #1 had been delusional free for more than two weeks.
-The NP stated Resident #1 was not a danger to self, but had self care deficits, which meant assisted living would be beneficial and safe.

Interview on 9/1/15 at 11:00 am with the mental health therapist who met with Resident #1 twice weekly from February 2015 to June 2015 onsite at the facility revealed:
-The resident was "pretty high functioning and did not need much assistance."
- She stated the resident became more distrustful and more withdrawn the later part of May 2015 and early June 2015.
-She stated the delusions regarding "Ed, the angel" were not considered significant as "Ed" did

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D 226	Continued From page 7 not tell Resident #1 to do anything adverse. -The therapist did not consider Resident #1 to be a danger to herself or others at anytime during the period she provided treatment . Interviews with 8 care staff and medication aides on 8/31/15 and 9/1/15 at various times revealed: -None of the staff interviewed were afraid of the resident or felt fear of harm from the resident. -Two of the staff interviewed mentioned they were worried about other residents being harmed by Resident #1, but did not have any specific event to refer to. -Six of 8 staff interviewed did not have any inappropriate physical contact directed towards them initiated by the resident. -One staff member stated the resident raised her fist and shook it at the staff member but the resident did not touch or swing at the staff member. -One staff member stated the resident got very close to her face and shook a finger at her, nearly touching her nose, but no contact was made. Based on interviews and record review, Resident #1 did not appear to be a danger to herself or a danger to others.	D 226		
D 229	10A NCAC 13F .0702 (e) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (e) The facility shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to	D 229		

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D 229	Continued From page 8 the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505. (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated. (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services. (4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide the POAs and resident with a Notice of Discharge and Hearing request via hand delivery to the resident and hand delivery or certified mail for the POA on the same date as the Notice of Discharge was written. The findings are: Review of the facility's "Adult Care Home Notice	D 229		

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D 229	Continued From page 9 of Transfer/Discharge" dated 8/7/15 revealed: -The selected reason for the notice was identified as "The safety of the resident or other individuals in the facility is endangered." -Under "Notification", the facility reported the POA was notified. -The planned discharge location was a nearby Behavioral Health Center where the resident was currently being treated. -The facility selected and checked the option of "The facility has convened the adult care home resident discharge team." -Additional documentation revealed the "no" box was checked and circled regarding the adult care home resident discharge team with notation "per DSS cty [county] monitor [name inserted] and dated 8/10/15 -The discharge notice was accompanied by the "Adult Care Home Hearing Request Form." -The notice of discharge was signed by the Administrator on 8/7/15. Interview with the resident's POAs on 8/31/15 at 8:50 pm revealed: -Neither POA had received a notice of discharge from the facility, either by hand delivery or by mail. -The POAs had received the notice of discharge via fax from the county Adult Home Specialist on 8/10/15. -Resident #1 was currently receiving treatment in a nearby Behavioral Health Center (BHC) since 7/20/15 with plans to returned to the facility upon discharge. -The POAs reported the discharge planner from the BHC had contacted the facility and themselves for discharge planning as the resident was ready to return to the facility the week of 8/10/15. -The POAs stated the resident had three other	D 229		

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hospitalizations in the past 2-1/2 years for medications adjustment and intensive therapy, the last being 8/24/14.
-The POAs stated they were told by the Administrator after the hospitalization discharge of 8/29/14 that if Resident #1 had another in-patient stay, she would issue a discharge; "no reason was given."

Review of the Resident Register revealed Resident #1 was admitted to the facility on 1/13/11.

Review of Resident #1's current FL-2 signed on 8/28/14, which was from the hospital discharge of 8/29/14, revealed:
-Diagnoses included Schizoaffective Disorder.
-Mood Indicators-Behavioral Symptoms under Section II documented she was not a wanderer, not verbally abusive, not physically abusive and not dangerous to self, others or property.
-The resident was assessed as needing limited assistance for bathing and dressing and prompting at time.

Interview with the Administrator on 9/1/15 at 8:00 am revealed:
-She had been the Administrator for approximately 2 years.
-She stated she wrote the discharge notice after the review of the hospital notes including the FL-2 created on 8/5/15 forwarded to her and the facility RN on 8/7/15.
-She stated according to the notes, Resident #1 was still having delusions regarding someone trying to kill her.
-The Administrator did not speak with the mental health provider at the BHC regarding Resident #1's current mental health status prior to issuing discharge notice.

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D 229	Continued From page 11 -The Administrator stated the facility's RN went to the BHC on 8/10/15 or 8/11/15 to assess the resident after the discharge notices had been sent. -She stated it was a collaborative corporate decision to initiate a notice of discharge on 8/7/15. -The Administrator sent a certified mailing containing the notice of discharge and appeals request form to Resident #1 in care of the BHC on 8/7/15 and received notice of delivery to the BHC on 8/10/15. -She did not hand deliver the notice to the resident. -She stated she did not know if the resident received the certified mailing. -The Administrator also sent a certified mailing containing the notice of discharge and appeals request on 8/7/15 to the POAs in care of the address/post office box in resident's record and have not received notice of delivery to the POAs as of 9/1/15. -The Administrator stated she did not call the POAs to discuss the impending discharge notice.	D 229		
D 231	10A NCAC 13F .0702 (g) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Resident (g) If an appeal hearing is requested: (1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and (2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of	D 231		

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D 231	Continued From page 12 discharge specified in Paragraph (c) of this Rule. This Rule is not met as evidenced by: Based on record review and interview, the facility discharged the resident before the final decision resulting from the appeal had been rendered. The findings are: [Refer to Tag 927, G.S. 131D-21 (17)] Review of the Decision rendered on 8/24/15 by the Hearing Officer, Department of Health and Human Services revealed: -The Hearing was conducted on August 18, 2015, via teleconference with the facility representatives, both of the POAs and regional long term care Ombudsman in attendance. -Based on the "Findings of fact and Conclusions of Law", the Hearing Officer's documented Decision was to reverse the Notice of Discharge issued on August 7, 2015. Review of an "Adult Care Home Notice of Transfer/Discharge" issued by the facility on 8/7/15 while the resident was receiving inpatient treatment at a nearby Behavioral Health Center revealed: -The selected reason for the notice was identified as "The safety of the resident or other individuals in the facility is endangered." -Under "Notification", the facility reported the POA was notified. -The planned discharge location was a nearby Behavioral Health Center where the resident was currently being treated. -The facility selected the option of "The facility has convened the adult care home resident discharge team." -Additional documentation revealed the "no" box	D 231		

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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) COMPLETE DATE
D 231	Continued From page 13 was checked and circled regarding the adult care home resident discharge team with notation "per DSS cty [county] monitor [name inserted] and dated 8/10/15. -The discharge notice was accompanied by the "Adult Care Home Hearing Request Form." -The notice of discharge was signed by the Administrator on 8/7/15. Interview with the resident's POAs on 8/31/15 at 8:50 pm revealed: -The POAs had received the notice via fax from the county Adult Home Specialist on 8/10/15. -Resident #1 is currently receiving treatment in a nearby Behavioral Health Center (BHC) since 7/20/15. -The POAs reported the discharge planner from the BHC had contacted the facility and themselves for discharge planning as the resident was ready to return to the facility the week of 8/10/15. -The POAs stated they were told by the Administrator after the hospitalization discharge of 8/29/14 that if Resident #1 had another in-patient stay, she would issue a discharge; "no reason was given." -The POAs stated the facility had not mentioned to the family there were other behavioral problems which were not currently being addressed prior to 7/17/15.	D 231		
D 233	10A NCAC 13F .0702 (i) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care	D 233		

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	HAL049030	A. BUILDING: _____ B. WING _____	C 09/01/2015

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D 233	Continued From page 14 facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to rescind a discharge notice for a sampled resident (Resident #1) when there was no physician-documented level of care change for the resident. The findings are: Review of the facility's "Adult Care Home Notice of Transfer/Discharge" dated 8/7/15 revealed: -The selected reason for the notice was identified as "The safety of the resident or other individuals in the facility is endangered." -Under "Notification", the facility reported the POA was notified. -The planned discharge location was a nearby Behavioral Health Center where the resident was currently being treated. -The facility selected the option of "The facility has convened the adult care home resident discharge team." -Additional documentation revealed the no box was checked and circled regarding the adult care home resident discharge team with notation "per DSS cty [county] monitor [name inserted] and dated 8/10/15 -The discharge notice was accompanied by the "Adult Care Home Hearing Request Form." -The notice of discharge was signed by the Administrator on 8/7/15.	D 233		

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D 233	Continued From page 15 Review of the pre-discharge FL-2/Level of Care Screening Tool created by the nearby Behavioral Health Center (BHC) on 8/5/15 and faxed to the facility on 8/7/15 revealed: -The resident was assessed as constantly oriented to person, place and time. -The Mood Indicators-Behavioral Symptoms section documented she was not a wanderer, not physically abusive, not verbally abusive and not a danger to self, others or property. -The resident was assessed as independent in all areas of daily living but required supervision with eating and diet. Review of the resident recorded revealed: -The resident was admitted to the facility on 1/13/11. -There were three previous hospitalizations for medication adjustment and behavioral therapy related to her bipolar disorder and paranoia on 3/25/13, 5/30/13 and 8/29/14. -There were no other Discharge Notices documented or available for review and at each discharge, assisted living was the recommended level of care and returned to the current facility. Interview with the BHC mental health provider/Nurse Practitioner (NP) on 9/1/15 at 1:57 pm revealed: -The NP stated Resident #1 was ready to return to her home [the facility]. -The NP stated Resident #1 was not a danger to self and is appropriate for assisted living. -The NP reported a note to the facility was sent on 8/10/15 stating she was not a danger to self and was appropriate for assisted living. -The NP stated the software they use for electronic notes sometimes carried comments over from previous notes, but that Resident #1 had been delusional free for more than two	D 233		

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D 233	Continued From page 16 weeks. -The NP stated Resident #1 was not a danger to self, but had self care deficits, which meant assisted living would be beneficial and safe.	D 233		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the rights of all residents were maintained and exercised without hindrance for 1 of 5 residents sampled (Resident #1) related to resident discharge. The findings are: Based on interview and record review, the facility failed to assure the rights of 1 of 5 sampled residents (Resident #1) were protected by failing to provide a valid medical reason for discharge, giving 30 days advance notice and failed to allow the resident to reside in the facility until the appeal was resolved. [Refer to Tag 927, G. S. 131D-21(17)] Review of the Decision rendered on 8/24/15 by the Hearing Officer, Department of Health and Human Services revealed: -The Hearing was conducted on August 18, 2015, via teleconference with the facility representatives, both of the POAs and regional long term care Ombudsman in attendance.	D 338		

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D 338	Continued From page 17 -Based on the "Findings of fact and Conclusions of Law", the Hearing Officer's documented Decision was to reverse the Notice of Discharge issued on August 7, 2015.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to treat the smpled resident (Resident #1) with respect, consideration and dignity related to discharge of a resident. The findings are: A. Based on interviews and record reviews, the facility failed to assure the reason of discharge of 1 of 5 sampled residents (Resident #1) was justified. [Refer to Tag 0226, 10A NCAC 13F.0702(b)(1-6).] B. Based on record review and interview, the facility failed to provide the POAs and resident with a Notice of Discharge and Hearing request via hand delivery to the resident and hand delivery or certified mail for the POA on the same date as the Notice of Discharge was written. [Refer to Tag 0229, 10A NCAC 13F.0702 (e)(1-2).] C. Based on record review and interview, the facility discharged the resident before the final	D911		

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D911	Continued From page 18 decision resulting from the appeal had been rendered. [Refer to Tag 0231, 10A NCAC 13F.0702 (g)(2).] D. Based on record review and interview, the facility failed to rescind a discharge notice for a sampled resident (Resident #1) when there was no physician-documented level of care change for the resident. [Refer to Tag 0233, 10A NCAC 13F.0702 (i).]	D911		
D927	G.S. 131D-21(17) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 17. To not be transferred or discharged from a facility except for medical reasons, the residents' welfare, nonpayment for the stay, or when the transfer is mandated under state or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as state and federal rules and regulations governing the transfer or discharge of residents from nursing homes.	D927		

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D927	Continued From page 19 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure the rights of 1 of 5 sampled residents (Resident #1) were protected by failing to provide a valid medical reason for discharge, giving 30 days advance notice and failed to allow the resident to reside in the facility until the appeal was resolved. The findings are: Review of an "Adult Care Home Notice of Transfer/Discharge" issued by the facility on 8/7/15 while the resident was receiving inpatient treatment at a nearby Behavioral Health Center revealed: -The selected reason for the notice was identified as "The safety of the resident or other individuals in the facility is endangered." -Under "Notification", the facility reported the POA was notified. -The planned discharge location was a nearby Behavioral Health Center where the resident was currently being treated. -The facility selected the option of "The facility has convened the adult care home resident discharge team." -Additional documentation revealed the "no" box was checked and circled regarding the adult care home resident discharge team with notation "per DSS cty [county] monitor [name inserted] and dated 8/10/15. -The discharge notice was accompanied by the "Adult Care Home Hearing Request Form." -The notice of discharge was signed by the Administrator on 8/7/15. Interview with the resident's POAs on 8/31/15 at 8:50 pm revealed:	D927		

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D927	Continued From page 20 -Neither POA had received a notice of discharge from the facility, either by hand delivery or by mail. -The POAs had received the notice via fax from the county Adult Home Specialist on 8/10/15. -Resident #1 is currently receiving treatment in a nearby Behavioral Health Center (BHC) since 7/20/15. -The POAs reported the discharge planner from the BHC had contacted the facility and themselves for discharge planning as the resident was ready to return to the facility the week of 8/10/15. -The POAs had taken the resident to her treating mental health provider on 7/17/15 for a routinely scheduled office visit. -The POAs reported to the doctor they were concerned regarding her increased paranoid symptoms in spite of the gradual medication adjustments the doctor had been making. -The POAs stated the doctor had been adjusting the resident's medications for several months but was not getting the results he had wanted. -The doctor chose to admit Resident #1 for in-patient treatment to provide a safer environment for medication adjustment. -The POAs stated the resident had three other hospitalizations in the past 2-1/2 years for medication adjustment and intensive therapy, the last being in August 2014. -The POAs stated they were told by the Administrator after the hospitalization discharge of 8/29/14 that if Resident #1 had another in-patient stay, she would issue a discharge; "no reason was given." -The POAs stated the facility had not mentioned to the family there were others behavioral problems which were not currently being addressed prior to 7/17/15.	D927		

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D927	Continued From page 21 Interview with the Administrator on 9/1/15 at 8:00 am revealed: -She had been the Administrator for approximately 2 years. -She stated Resident #1 became more withdrawn prior to her regular appointment with the doctor but she did not notify the doctor of her observations. -The Administrator was not afraid of Resident #1 and was not aware of any resident to staff physical contact recently. -She stated she wrote the discharge notice after the review of the hospital notes forwarded on 8/5/15. -She stated according to the notes, Resident #1 was still having delusions regarding someone trying to kill her. -The Administrator did not speak with the mental health provider at the BHC regarding Resident #1's current mental health status prior to issuing discharge notice. -The Administrator stated the facility's RN went to the BHC on 8/10/15 or 8/11/15 to assess the resident. -She stated it was a collaborative corporate decision to delivery a notice of discharge on 8/7/15. -The Administrator sent a certified mailing containing the notice of discharge and appeals request form to the Resident in care of the BHC on 8/7/15 and received notice of delivery to the BHC on 8/10/15. -She did not hand deliver the notice to the resident. -The Administrator sent a certified mailing containing the notice of discharge and appeals request from the the POAs in care of the address/post office box in resident's record and have not received notice of delivery to the POAs.	D927		

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D927	Continued From page 22 Interview with the facility's RN on 9/1/15 at 9:15 am revealed: -The RN received a call from the BHC requesting discharge back to the facility on 8/4/15 or 8/515. -The RN could not go to the BHC until 8/11/15 for assessment. -She stated the discharge notice was written on 8/7/15 after review the notes provided by the BHC which alluded to the resident still having delusions and was a danger to self. -When the RN completed her onsite assessment at the BHC, she did not speak with the mental health provider or the therapist regarding Resident #1's current mental health on 8/11/15. -The RN felt the resident was still paranoid. -The RN did not believe Resident #1's behavior was worse this hospitalization versus the hospitalization of 8/29/14. -The RN stated she was not fearful of Resident #1, but feared for her staff. -The RN stated Staff had reported to her Resident #1 had "shook a finger at a medication aide's face and very nearly touched her nose" in July 2015. Interview with the BHC mental health provider/Nurse Practitioner (NP) on 9/1/15 at 1:57 pm revealed: -The NP Resident #1 was ready to return to her home [the facility]. -The NP stated Resident #1 was not a danger to self and is appropriate for assisted living. -The NP reported having sent a note to the facility on 8/10/15 stating she was not a danger to self and was appropriate for assisted living. -The NP stated the software they use for electronic notes sometimes carried comments over from previous notes, but that Resident #1 had been delusional free for more than two weeks.	D927		

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D927	Continued From page 23 -The NP stated Resident #1 was not a danger to self, but had self care deficits, which meant assisted living would be beneficial and safe. -The NP stated the resident repeatedly asked when she could go home and why she was not allow to go home. -The NP stated the resident considered the assisted living facility she had been a resident in for the last 4 years to be her "home." Interview on 9/1/15 at 11:00 am with the mental health therapist who met with Resident #1 twice weekly in the facility from February 2015 to June 2015 revealed: -The resident was "pretty high functioning and did not need much assistance." - She stated the resident became more distrustful and more withdrawn the later part of May 2015 and early June 2015. -She stated the delusions regarding "Ed, the angel" were not considered significant as "Ed" did not tell Resident #1 to do anything adverse. -The therapist did not consider Resident to be a danger to herself or others at anytime during treatment. -The therapist did not know why the resident could not be returned to her home after discharge. Further interview with the POAs on 8/31/15 at 9:30 pm revealed: -The POAs requested an appeals hearing upon receipt of the faxed notice of discharge and hearing request from from the county Department of Social Services Adult Home Specialist. -The hearing was held via teleconference on August 18, 2015. -The POAs stated the the Notice of Discharge issued to Resident #1 by the facility was reversed as of 8/24/15 by the Hearing Officer.	D927		

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D927	Continued From page 24 Review of the Decision rendered on 8/24/15 by the Hearing Officer, Department of Health and Human Services revealed: -The Hearing was conducted on August 18, 2015, via teleconference with the facility representatives, both of the POAs and regional long term care Ombudsman in attendance. -Based on the "Findings of fact and Conclusions of Law", the Hearing Officer's documented Decision was to reverse the Notice of Discharge issued on August 7, 2015. Interview with the Business Office Manager (BOM) on 9/1/15 at 10:00 am revealed: -The facility had received a check from the POAs dated 8/10/15 and posted on 8/11/15 for the next month's care in the amount of $4057.00. -The BOM requested a refund to the family from the corporate office after direction from the Administrator. -A check in the amount of $3107.99 was issued on 8/26/15 and sent overnight to the POA. -The BOM stated the reason given for the refund request from the Administrator was "the community discharged the resident do to Safety of others." Further interview with the Administrator on 9/1/15 at 8:00 am revealed the room hold policy in effect required a daily room charge as long as there was still furniture in the room unless other arrangements were made. Observation of Resident #1's room on 8/31/15 at 2:30 pm revealed: -The bed was made with personal belongings on the dresser top and in the bathroom. -There were personal pictures on the wall and surfaces.	D927		

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D927	Continued From page 25 -A walker was in the room with the resident's name on it. -There were clothes in the hamper and clothes hanging in the closet. Based on observation, record reviews and interviews, the resident had been prevented from returning to the "home" which was familiar to her, contained her personal belongings and was ready for her occupation after the facility failed to provide an orderly discharge process protecting the resident's rights.	D927		