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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 203</td>
<td><strong>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</strong></td>
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Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.

Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.

The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This REQUIREMENT is not met as evidenced by:

- Based on staff and physician interview and record review the facility failed to give the required discharge notice to 1 of 2 resident’s (Resident #1) when the facility determined the resident no longer required skilled nursing care but the resident indicated she was not yet ready for discharge to a lower level of care. The findings included:
  - Resident #1 was admitted 2/21/14 with cumulative diagnoses including acute myelitis, shunted pseudotumor cerebri, depression and anxiety.
  - Review of the Admission Minimum Data Set (MDS) dated 3/4/14 revealed Resident #1 was cognitively intact. Review of the Participation in Assessment and Goal Setting section of the MDS revealed that Resident #1 participated in the assessment and "expects to be discharged to another facility/institution."
  - Review of the Care Plan revealed a plan of care for "Resident plans to be in facility for STR (Short Term Rehabilitation)." The approaches focuses on strategies to facility discharge back home to the community with home health.
  - Review of the 72 hour meeting notes dated 3/6/14 revealed the following documentation under the heading "what are the resident's long term plans" : "unsure of LT (long term) plans - lived alone prior to admission.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents
Res (resident) is planning to transfer to ALF (Assisted Living Facility) - (name of facility) in Albemarle. According to the signatures present on the form the resident and her mother attended the meeting along with the Social Worker and 4 other staff members.

Further review of the Care Plan revealed the discharge plan of care had a hand written strike through it and a hand written notation that it was discontinued on 3/25/14. An updated discharge plan of care was not present in the Care Plan.

Review of the Social Progress Notes from 2/24/14 through 5/20/14 (the date of the last entry) revealed:
2/24/14:   " Res in facility for STR. "
3/25/14:   " Res plans to be in facility for LTC (long term care). States she is unable to care for herself alone in her home and states she wants to be transferred to an ALF or another SNF near home once ready. "
5/20/14:    " Res has adjusted to being in facility. Enjoys her private room. "

Review of the Medical Record from admission on 2/21/14 to discharge on 7/8/14 revealed that a Discharge notice with the reason for discharge and information about the resident’s right to appeal was not present.

Review of the North Carolina Medicaid Program Long Term Care Services form dated 6/26/14 revealed Resident # 1’s level of care was checked as domiciliary; the SNF level of care was unchecked. This form was signed by the physician.

Review of the Physician’s orders dated 7/2/14 revealed an order to discharge Resident #1 to an Assisted Living Facility once a bed was available.

Review of the Nursing Notes revealed Resident # 1 was discharged to an Assisted Living Facility on 7/8/14. During interview with the Ombudsman, on 10/8/14 at 11:21 AM, she indicated that prior to discharge the resident had told her that she did not feel ready to leave the facility because an ALF would not be able to manage the level of care she still required. The Ombudsman also indicated that the resident was not in agreement with the determination that she had met her maximum potential or that she no longer required skilled nursing care. The Ombudsman said that staff at the facility were aware of the resident’s concerns and she therefore thought Resident #1 would receive a Discharge Notice prior to discharge.

Interview with the Social Worker on 10/8/14 at 4 PM revealed that she did not initiate a Discharge Notice for Resident #1 because the Resident’s plan at admission had been to stay in the facility for Short Term Rehabilitation and then be discharged to an ALF and because the resident no longer required skilled nursing care as determined by the physician.

Interview with the Administrator on 10/9/14 at 8 AM revealed that he believed that the resident’s discharge had been self-initiated because when she was first admitted she said that her goal was discharge. He indicated that he was not aware a Discharge Notice was required when resident’s change their mind about being discharged and question the facility’s (physician’s) determination of their level of care, as discharge draws closer.

Interview with the Physician on 10/9/14 at 10:49 AM revealed within several days of discharge the physician, Administrator and Social Worker met with Resident # 1 in her room. He indicated that Resident # 1 had said that she had to stay at the facility longer because her functioning was not at the level she wanted it to be at yet. He added that Resident # 1’s progress had plateaued and she had reached her maximum potential and did not qualify for further rehabilitation services. He also indicated that Resident # 1 appeared to have become comfortable with the facility and to appreciate the care and attention she received there and that she was also having a hard time accepting that she had reached her maximum potential. The Physician further
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revealed that he explained to the resident why she did not require skilled nursing care anymore. He said Resident #1 then started asking about what her orthopedist thought of this, but since her limitations were not orthopedic related, the Physician said there was no need to delay discharge in order to complete a referral to orthopedics. The Physician also indicated that he was not aware the facility should have completed a discharge notice in this case.