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	345408	A. BUILDING _____ B. WING _____	C 05/24/2019

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F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by:	F 626		6/11/19

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

Electronically Signed | 06/07/2019

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F 626	Continued From page 1 Based on record review and staff interviews, the facility failed to admit a resident after she returned to the facility from the hospital for 1 of 3 residents reviewed for admission/discharge. (Resident #1). Finding included: The resident was initially admitted to the facility on 4/11/19 with the diagnoses of hypertension, severe depression, and hypothyroidism. The resident also had behaviors of sadness, despairing, and withdrawal. The resident had care plans (4/25/19) in place for falls, activities of daily living, short-term memory loss, depression, and psychosocial well-being. An intervention for the depression care plan stated to observe, document, and report any risk for harm to self. Another intervention under psychosocial well- being stated to initiate referrals as needed. Resident #1 Discharge Minimum Data Set (MDS) dated 5/2/19 revealed the resident had moderately impaired cognitive skills. The resident required limited assistance with bed mobility and toilet use. The resident required extensive assistance with transfers and supervision with locomotion, dressing, and personal hygiene. The resident was independent with eating. She also required total assistance with bathing. The resident was occasionally incontinent of bladder and always continent of bowel. The resident had an unplanned discharge, but return was anticipated. The resident was discharged to the hospital. The MDS also revealed that active discharge planning was still occurring for the resident to return to the community.	F 626	Resident #1 has been admitted to another SNF. The facility did not communicate the need for further clinical information to the hospital before their attempt to return the resident to the facility and the hospital discharged her to another SNF. All residents that are discharged to the hospital could be affected. The Director of Nursing reviewed the last 30 days of discharges to the hospital and there has been no resident that the facility failed to readmit if the resident was ready to return to the facility. This audit will be completed by 6/10/19. The District Director of Clinical Services (DDCS) provided in-service to the Administrator, Director of Nursing, Admissions, the Nurse Managers and the Social Workers on Federal Tag F626 as it relates to allowing a resident to return to facility to the first available bed when discharged to the hospital. The staff educated are the decision makers related to Admissions and Readmissions to the facility. This in-servicing will be completed by 6/10/19. The DDCS will select 5 random residents that are sent to the hospital weekly x 4 weeks and review the plan for readmission with the Director of Nursing to the first available bed. The DDCS will select 5 random residents monthly for two more months and review the plan for readmission with the Director of Nursing	

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F 626	Continued From page 2 A note dated 5/2/19 from the Physician's Assistant revealed the patient fell this afternoon and per staff (therapy and nursing) she continued to have severe confusion and was not acting as she did when she first arrived at facility. She was refusing medications for the past few days and wasn't talking as she did previously. She fell on her left hand/ wrist and developed hematoma. The resident's psychiatric assessment revealed she had a flat (affect) and had poor eye contact. Resident #1 also laughed intermittently, shook her head, and only said a few words, which were nonsensical ("the eye piece is in my throat"). When asked about going to emergency room, the resident said, "whatever they want". The plan included that the resident was at high risk of self-harm with falling and impulsivity. By not taking her medications, the resident was at a high risk of withdrawal symptoms from multiple medications. The patient was seen by psychiatric nurse practitioner with medication adjustments, but the patient was not taking the medications. The resident was sent to the hospital with hopes of inpatient psychiatric evaluation for self-harm risk, catatonia and psychosis. A physician's telephone order was written on 5/2/19 to send the resident to the hospital "for inpatient psychiatric evaluation due to a patient with acute psychosis, catatonia, refusing medications, and risk of self-harm." A nursing note dated 5/2/19 revealed Resident #1 was sent to the hospital. Emergency Room report dated 5/17/19 revealed that the emergency room doctor had spoken with the nursing home about Resident #1. The facility's main concern was the resident fell on her	F 626	to the first available bed. The results of the audit will be presented at QAPI to evaluate effectiveness. The QAPI Committee will make changes and recommendations as indicated. The Administrator and Director of Nursing are responsible for implementing this Plan of Correction.	

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F 626	Continued From page 3	F 626		

left hand and wrist, was refusing to take medications for several days, had a very flat affect, and was "staring into space", which was a change in her status. The resident's laboratory work from the previous day was normal (at the facility). Additionally, resident #1 had recently expressed suicidal thoughts, and had psychiatry see her; The psychiatry consultant wanted the resident evaluated for catatonia vs. psychosis.

Hospital records (which was provided to the facility for clinical review of Resident #1 hospital stay) dated 5/17/19 revealed under psychiatric mental status evaluation that Resident #1 was calm, appropriate and had good eye contact. The resident had no suicidal or homicidal ideation and no apparent delusions or preservations. The resident was alert and her recent and remote memory was intact. Her insight and judgement had improved. The resident was diagnosed with encephalitis, hypoactive delirium (resolved), bacterial conjunctivitis and clostridium difficile. The note also stated that suicide precautions and a sitter were not necessary.

Record review of Resident's #1 revealed, Resident #1 never returned as a resident at the facility but was transferred to another nursing home from the hospital.

Admissions coordinator #1 was interviewed on 5/24/19 at 11:00 AM. She stated a nurse or clinical manager (DON, unit manager or ADON) would review the clinical aspect of the paper work and will let them (admissions) know if residents were appropriate to return to the facility. Then they would report back to the hospital if it was ok to readmit the resident. Once the hospital contacts them with an admitting time, then the

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F 626	Continued From page 4	F 626		

facility sends a broadcast text message out to the interdisciplinary team stating the resident was coming back. This broadcast would include the room and time the resident was being remitted to the facility. Resident #1 was approved to come back to the facility. They broadcasted to the staff that Resident #1 would be returning to the facility (5/17/19). Resident #1 was assigned room 119 and was scheduled to return at 2:00 PM (5/17/19). Once the broadcast went out, the social worker came to her about some clinical concerns about the resident. She revealed she went to the administrator and asked him what they should do. The administrator told her to call the hospital and told them not to send Resident #1 to the facility. They reached out to the case manager at the hospital to try and stop the discharge. However, the Resident was already in route to the facility. They canceled the admission to the facility at 3:05 PM on 5/17/19. The resident was returned to the hospital. She stated the resident was not rescheduled a time to return to the facility.

Admissions coordinator #1 was interviewed again on 5/24/19 at 4:30 PM. Per report from the admission coordinator, after the administrator reached out to the team, she (admission's coordinator) reached out to the admission's team at the hospital and told them to hold off on discharging Resident #1 to the facility. However, Resident #1 had already left the hospital. She revealed this occurred around 3:00 PM on 5/17/19. She stated she met the resident at the front of the facility and stated to the transporters that they (the facility) would not be able to admit the resident as they didn't have all the information they needed for admission. The transporters asked what information they needed, and the

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F 626	Continued From page 5	F 626		

admission's coordinator stated it was required information they had requested from the hospital. She stated the transporters reached out to someone via cell phone and then sent the resident back to the hospital.

The social worker (SW) was interviewed on 5/24/19 at 10:42 AM. The SW stated the facility's marketers would let the admissions staff know if a resident was returning to the facility. Then the admissions staff would let administration know if the resident was coming back to the facility. The SW stated resident #1 went to the hospital because she wanted to commit self-harm. The facility sent a broadcast (via text) to announce that the resident was coming back to the facility on 5/17/19. However, she was concerned that the resident's issues were not addressed clinically. The facility staff had told the hospital they were trying to figure out a situation related to Resident #1 psychiatric condition. The resident was sent to the facility on 5/17/19 and then back to the hospital. She thought this occurred because the resident's psychiatric concerns were not addressed at the hospital.

The Administrator was interviewed on 5/24/19 at 11:30 AM via phone. The administrator stated he was concerned about the resident's safety. They sent her to the hospital for a psychiatric evaluation. They needed to know that the resident was safe to return to the facility and there was no psychiatric evaluation provided to them. He revealed he would usually direct the social worker to get this type of information for him. He stated it was brought to his attention, when the resident was in route to the facility, when the facility stated they cannot take the resident back until they received the information they needed. He stated

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F 626	Continued From page 6	F 626		

he never received any information regarding the psychiatric evaluation from the hospital. The administrator reported, when Resident #1 returned, he did not know if the resident made it through the front door of the facility. He stated before the resident was admitted back to the facility, he needed to see her psychiatric evaluations. The administrator told the social worker he needed to see the paperwork (referring to a psychiatric report at the hospital) before he could let the resident come back.

The Administrator was interviewed again on 5/24/19 at 1:58 PM. The administrator stated he only asked the social worker for more psychiatric information from the hospital and never received information/evaluation on it. The administrator said he wanted a written evaluation that addressed the issues the resident went to the hospital for, as he thought a deeper issue was going on. He didn't just want the check sheet the hospital had sent but needed a detailed evaluation to address and manage the resident's behaviors specifically in case this was to occur again. The brief hospital records they received did not address this.

The Director of Nursing (DON) was interviewed on 5/24/19 at 1:03 PM. The DON stated the Physician's Assistant had a concern that Resident #1 was having passive thought of self-harm. The facility was worried that the resident was having psychotic episodes as the resident had periods of talking and then not talking. The resident went to the hospital for a psychiatric evaluation and the potential for self-harm. The DON revealed that she got a call from the emergency room (ER) doctor the night the resident when to the hospital. She stated the medications were reviewed with

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F 626	Continued From page 7	F 626		

the ER doctor and they discussed why resident #1 was sent to the ER. The ER doctor stated he didn't have a medication list or the reason why she was sent to the hospital. The DON stated to the ED doctor, the facility would need something to say that Resident #1 wasn't going to harm herself, so they would know the resident would be safe at the facility. She stated she got the text message (broadcast) that Resident #1 was returning to the facility but then it was canceled. She stated the resident's referral didn't address the psychiatric condition she was sent to the hospital for and the social worker had some concerns about what the hospital did to address the issue. While they were asking for more information from the hospital, the resident showed up at the facility. The DON reported the facility never received a psychiatric evaluation (only a short hospital review summary) from the hospital. The facility needed something to say the resident wasn't going to harm herself because the facility must ensure the resident's safety.

The Director of Nursing was interviewed on 5/24/19 at 4:23 PM. The DON stated the assessment provided by the hospital was not a full psychiatric consult and evaluation. The unit manager just had briefly looked over the paperwork. There usually was a psychiatric evaluation in the records from the hospital but there wasn't one for Resident #1. She revealed the social worker asked the hospital about the requested information and they talked with admission coordinators about getting more information. She stated Resident #1 was not denied admission to the facility, but the facility just needed additional information on her psychiatric condition before readmission. The admission coordinator also requested the information but

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F 626	Continued From page 8	F 626		

never got it when the resident was already in route to the facility. The DON said the resident could come back to the facility, if there was a psychiatric evaluation.

The Unit Manager was interviewed on 5/24/19 at 1:50 PM. The unit manager stated on 5/17/19, she reviewed the information sent from the hospital about Resident #1 (see hospital report above). They sent Resident #1 to the hospital for a psychiatric evaluation and she thought the resident could return to the facility from a clinical stand point. There was a psychiatric progress note that didn't mention anything negative about the resident's psychiatric condition and the hospital had completed some tests, which were also negative. The hospital records did not mention anything about self-harm. After she reviewed the packet, she let the admissions staff know and they send a broadcast out stating the resident was coming back to the facility. After the broadcast went out to staff, the social worker started asking about the resident's risk for self-harm and they started asking the admission staff to get more information and a psychiatric evaluation.

The Hospital Case Manager was interviewed on 5/24/19 at 4:16 PM. The hospital care manager stated he didn't have any official documentation that stated Resident #1 could return to the facility except for his computer screen that turned green indicating that the resident was accepted at the facility. He said he previously talked to the Liaison, about the admission scheduled for 5/17/19. Resident #1 was able to discharge from the hospital and that every internal medicine doctor at the hospital was also a certified in psychiatry. The hospital case manager stated the

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F 626	Continued From page 9	F 626		

resident had no behaviors at the hospital and was safe to return to the facility. The facility never contacted him requesting addition information.

The social worker has interviewed again on 5/24/19 at 4:43 PM. The SW stated she never received a call/paperwork from the hospital about the additional information requested.

The Hospital Liaison was interviewed on 5/24/19 at 4:56 PM. The hospital liaison revealed the resident was sent to the hospital for some psychiatric issue and the facility was asking for documentation about the psychiatric issue. She stated the facility was waiting for the documentation, but she was not involved in this part of the admission. She was only involved with the PASRR component.

The DON was interviewed on 5/24/19 at 5:49 PM. The DON stated, she would expect to receive the appropriate information for residents to be readmitted to the facility.