STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted on 03/19/25 through 03/20/25. Event ID# QDHG11. The following intakes were investigated NC00228435, NC00227893, NC00227581 and NC00228327. 11 of the 11 complaint allegations did not result in deficiency.	F 000		
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process 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- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each 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	F 660		4/4/25

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

Electronically Signed | 04/04/2025

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 correction is requisite to continued program participation.

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F 660	Continued From page 1	F 660		

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 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.
(ix) Document, complete on a timely basis based

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F 660	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident and family member interviews, the facility failed to develop and implement effective discharge planning that ensured a resident would have the necessary durable medical equipment when she was discharged home to include a hospital bed, gel bed overlay with mattress, half side rails, a trapeze bar, and oxygen supplies for 1 of 4 residents reviewed for discharge (Resident #1). Resident #1 stated she was not provided with equipment for oxygen therapy and would get short of breath, and it would wake her up. Resident #1 reported she would cough, and it made her throw up at night. In addition, Resident #1 indicated that the hospital bed was not delivered, and she was sleeping in a recliner due to the shortness of breath which resulted in edema in her ankles and worsening of gastroesophageal reflux disease (GERD) symptoms. The findings included: Resident #1 was admitted to the facility on 1/22/25 with diagnoses including GERD, sleep apnea, and rhabdomyolysis (a serious condition caused by a direct or indirect muscle injury and could lead to serious complications such as	F 660	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F660 Discharge Planning Process 1. Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice: Resident # 1 discharged home on 02/05/25 and when reviewing the communication between the DME provider, it was determined that the resident□s hospital bed and mattress and oxygen had not been delivered. Resident #1 no longer resides at the facility. The Discharge planner called Resident #1□s daughter on 2/10/2025 to discuss the ordered DME and if the ordered DME had been delivered. The oxygen had not been delivered. Resident #1 confirmed that	

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F 660	Continued From page 3 kidney failure). A review of physician order dated 1/22/25 revealed Resident #1 received oxygen therapy at two liters per minute via nasal cannula, every day and night shift. An admission Minimum Data Set (MDS) on 1/29/25 revealed Resident #1 was cognitively intact. Resident #1 was not coded for oxygen use. The MDS was coded for Resident #1 to discharge back to the community. A review of Resident #1's Treatment Administration Record (TAR) revealed she received oxygen at two liters per minute via nasal cannula, every day and night shift from 1/22/25 to 2/5/25. A review of a physician order/note dated 2/5/25 and signed by the previous Medical Director revealed Resident #1 needed the use of durable medical equipment (DME) in her home. The equipment included a semi-electric hospital bed, a gel overlay for the mattress and a trapeze bar. The order described Resident #1 as having severe back pain and needed frequent changes in body position to alleviate the pain caused by arthritis. Resident #1 was described in the note as having a compromised circulatory status, therefore requiring pressure reducing support surface to treat and prevent skin breakdown. Resident #1 also needed a trapeze bar to get in and out of bed. The order did not include oxygen supplies. A review of an itemized physician's order form dated 2/5/25 and signed by the previous Medical Director included a semi-electric hospital bed,	F 660	DME was delivered on 2/12/2025. Resident #1□s daughter also confirmed that home health had started treatment 2/6/25 after discharging from the facility. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice: An audit was conducted by the Regional Director of Discharge planning of the last 30 days of discharges to the community to ensure that all home health services and Durable Medical Equipment (DME), including oxygen and hospital beds, if ordered. were arranged. The audit was completed on 4/03/2025. The Discharge planner with the assistance of the Regional Director of Discharge planning completed an audit last 30 days of discharges on 04/03/2025 to assure that all ordered equipment has been ordered and received. No other concerns were identified during this audit. The Discharge Planner followed up with all discharged Residents/ Resident Representatives who required Home Health services and/ or DME equipment when they discharged from the facility to ensure that all equipment needs had been delivered. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Effective 4/03/2025, the discharge planner will review physician orders, including	

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F 660	Continued From page 4 wheelchair, gel overlay, a mattress, half bed rails, and a trapeze bar. The order did not include oxygen supplies. A review of a nursing progress note written by Nurse #1 dated 2/6/25 revealed Resident #1 was given patient discharge instructions. Nurse #1 reviewed medications with Resident #1 who voiced understanding. She was discharged with medications and prescriptions. A review of the discharge summary dated 2/6/25 and signed by Nurse #1 revealed Resident #1 was discharged home with home health services and needs for a hospital bed and walker. The discharge summary did not include the need for any oxygen supplies and did not indicate Resident #1's use of oxygen at the facility. The discharge summary did not have contact information for the durable medical equipment provider and listed a bed and walker as the equipment needed by Resident #1. A telephone interview with Nurse #1 on 3/19/25 at 2:39 PM revealed she discharged Resident #1 home on 2/6/25. She stated the SW would order any durable medical equipment for any residents discharging home. She stated she printed a discharge summary for Resident #1 and went through her medications with her. Nurse #1 stated if oxygen was listed on the summary, she would have discussed it with Resident #1. She stated nursing would typically fill out the device section of the assessment. Nurse #1 explained if oxygen was not checked off on the discharge summary list for Resident #1, it would not have been ordered for the discharge. A telephone interview with a DME Company	F 660	those for oxygen use and any other required DME, prior to discharge and will arrange for the delivery of the ordered DMEs to the discharge address. The Discharge Planner will follow up with the DME company and Resident/Resident Representative to ensure that the equipment has been delivered. The Discharge Planner will call 24 hours after discharge to ensure the resident has everything they need and no further assistance is needed. Effective 4/03/2025, the discharge planner will notify the home health agency responsible for the residents□ care in the community about the ordered DMEs, ensuring confirmation of the delivery of the equipment for continuity of care. The Discharge Planner will follow up with the DME company and Resident/Resident Representative to ensure that the equipment has been delivered. The Discharge Planner will call 24 hours after discharge to ensure the resident has everything they need and no further assistance is needed. Education on the discharge planning process, including ensuring home health services are arranged, require DMEs including oxygen are ordered, and the communication of the ordered DME□s with the Home health agency was provided to the discharge planner by the administrator. The education also emphasized the importance of discharge planner to review all planned discharges with the Director of Nursing to ensure all	

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F 660	Continued From page 5 Representative on 3/19/25 at 12:47 PM revealed Resident #1 had not received her equipment in her home after her discharge. She stated Resident #1's family had called the equipment company many times inquiring why the bed and other equipment had not been delivered. A second telephone interview with a DME Company Representative on 3/20/25 at 9:08 AM revealed she spoke to Resident #1's family member for the first time on 3/10/25 but the family member had placed many calls to the call center requesting information about Resident #1's equipment. She stated the facility originally did not fax over the needed information to complete the DME order to include the medical need for the supplies requested. The DME Company Representative explained the DME requested was for the bed and the bed accessories. She did not know Resident #1 needed oxygen therapy, but added they would be able to get her the supplies she needed if the facility would send over an order and medical need for the oxygen. The DME Company Representative stated no DME, or supplies had been delivered to Resident #1 yet as they were waiting on the documents requested from the facility. A telephone interview was conducted with Resident #1's family member on 3/19/25 at 1:50 PM. She stated Resident #1 had not yet received the hospital bed or any equipment that came with the bed. The Family Member indicated Resident #1 did receive a walker and a bedside commode when she was discharged from the facility. She understood from the DME company that the correct information needed for the DME including oxygen supplies was not given by the facility during the discharge process. The Family	F 660	clinical needs have been communicated. This education was completed on 04/03/2025. This education will also be provided for any additional member added to the discharge planning department upon hire and annually by the Administrator. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur: Effective 04/03/2025, the Administrator or designee will audit planned discharges to ensure home health services have been ordered, required DME□s are ordered, and the home health Agency has been informed of the ordered equipment 5x/week x 2 weeks, then weekly x 2 weeks, then monthly for three months, or until the pattern of compliance is established. Effective 04/03/2025, the Discharge Planner will audit if DME was delivered to resident□s discharge address by contacting Resident/ Resident Representative 24 hours after being discharged from the facility. If there is an issue with DME equipment, a bed will be offered to the resident until the issue is resolved. This will be completed 5x week x 2 weeks, weekly x 2 weeks. Effective 04/03/2025, results of this audit will be reported by the administrator to the quality assurance and performance improvement committee monthly for three months for further resolution as needed.	

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F 660	Continued From page 6	F 660		

Member stated she called the call center at the durable medical equipment company many times. She stated the DME Company Representative was helping her to get the documentation needed for the equipment from the facility.

A second telephone interview with Resident #1's family member on 3/19/25 at 2:12 PM. She stated Resident #1 had continuous oxygen in the hospital prior to her admission at the facility. She revealed the facility did not provide Resident #1 a portable oxygen tank after discharge, and she wore oxygen every day during her stay at the facility.

A telephone interview with Resident #1 on 3/20/25 at 10:03 AM revealed she did not have her hospital bed, the gel overlay, the trapeze bar, or oxygen as of 3/20/25. She stated when she was in the facility, she had oxygen because when she was sleeping, her oxygen level would go down. Resident #1 stated she was not sent home with any oxygen equipment from the facility, and when she slept, she would get short of breath, and it would wake her up. Resident #1 reported she would cough, and it made her throw up at night. Resident #1 explained she had been sleeping in a recliner because of her shortness of breath and her GERD. She stated that because she has been in her recliner to sleep, her ankles were swollen, and they were not before when she was sleeping in an adjustable bed at the facility. Resident #1 stated her GERD has worsened because of not being able to sleep in an adjustable bed. Resident #1 indicated she had not been hospitalized since her discharge from the facility.

An interview with the Social Worker (SW) on

5. Completion date 04/04/2025

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F 660	Continued From page 7	F 660		

3/19/25 at 2:19 PM revealed Resident #1 discharged home on 2/6/25 with orders for home health services and equipment that included a hospital bed and accessories to include a trapeze bar, mattress and overlay and side rails. She stated Resident #1's discharge plan included a bed with other accessories and a walker. The SW indicated she created the DME order on 2/5/25 and sent over the paperwork in the ordering portal to start the ordering process with the DME company. The SW recalled on 3/10/25, Resident #1's family member called and stated they had not received the bed. The SW stated the DME company needed documentation that explained the necessity of the bed to fulfill the order. She stated she sent the information to the durable medical equipment company on 3/17/25 and she received a message from the contact at the durable medical equipment company on 3/19/25 that the documentation was approved. The SW explained she was not aware Resident #1 had an order for oxygen in the facility or needed oxygen therapy after discharge. The SW revealed she did not review residents' orders before discharge and nursing would have been responsible for alerting her to Resident #1's need for oxygen. She stated discharges were discussed during the morning meeting at the facility. The SW further stated she did not follow up with Resident #1 after her discharge from the facility. She explained she made the official request for DME supplies based on the reports given to her from other departments during the morning meeting.

An interview with the Unit Manager on 3/20/25 at 9:51 AM revealed he could not recall specifics about Resident #1's care but stated typically discharges were discussed in the morning

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F 660	Continued From page 8	F 660		

meeting. He stated supplies needed for a resident's discharge would be discussed and the SW would order anything needed for the discharge. The Unit Manager indicated nursing would typically inform the SW if oxygen was needed.

A telephone interview with the previous Medical Director on 3/20/25 at 11:55 AM revealed he had written the discharge orders for Resident #1 but explained he did not specially recall Resident #1 as he was temporally filling in as Medical Director for the facility. He stated if a resident used oxygen in a facility and still had the need for oxygen, then oxygen therapy should have been part of the discharge plan. The previous Medical Director explained that if he signed a physician's order for DME for a resident before discharge, then the equipment was necessary.

An interview with the Administrator on 3/20/25 at 11:04 AM occurred. She stated Resident #1 did not receive her bed and DME due to the need for additional information to document Resident #1's need for the equipment to fulfill the order. The Administrator indicated the facility reviewed discharges during the clinical part of their morning meeting but did not recall Resident #1's discharge discussion. She stated during this meeting all DME was reviewed for each resident discharging. The Administrator stated Resident #1's needs for oxygen should have been reviewed before she was discharged from the facility. She explained the SW should have followed up with Resident #1 before she left the facility on her needs. The Administrator explained the facility had implemented a plan in response to the discharge concerns with Resident #1 to improve coordination with DME

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F 660	Continued From page 9 and home health services for residents discharging home from the facility. The facility presented a plan of correction that was not accepted by the State Survey Agency. The facility failed to provide evidence of the audits being completed at the time the plan was completed. The interview with the SW on 3/19/25 revealed that she was not calling all discharges as stated she would in the plan but only called the residents who left against medical advice or had a lot of concerns and indicated that she was just recently been given this directive from her Regional Consultant. Furthermore, the ongoing monitoring failed to include the names of the residents that were audited upon discharge and what equipment was needed and verified to have been delivered to the discharged resident.	F 660		