STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675365	A. BUILDING _____ B. WING _____	**04/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PASADENA CARE CENTER	**4006 VISTA RD PASADENA, TX 77504**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving mistreatment or neglect were reported immediately or not later than 24 hours after the incident occurred to the State Agency, for 1 of 2 residents (CR #1) reviewed for neglect reporting in that: The facility failed to report an incident of elopement when CR #1 left the premises for over an hour. This failure could affect residents who required supervision and placed them at risk of injury, abuse or neglect. Findings include: CR #1 Record review of the face sheet for CR #1 revealed the [AGE] year-old former resident was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of the admission MDS with an ARD of 3/19/20 revealed CR #1 scored an 8 on the BI[CONDITION] indicating he had moderate cognitive impairment. The review further revealed the resident required 2 people to assist for bed mobility, hygiene and transfers and he required only set up assistance for ambulation. The review further revealed the resident had demonstrated verbal behaviors towards others and that he did not require the use of a wheelchair, walker or other assistive ambulatory device. The review revealed the resident was frequently incontinent of both bowel and bladder. Record review of nurses' note dated 3/29/20 revealed CR #1 succeeded in exiting the facility unaccompanied and was found momentarily in the parking lot at the facility. Record review of nurses' note dated 3/31/20 read in part, .At 5:20 AM. my attention was drawn that resident has left the facility unaccompanied and unauthorized. After a search of the nearby surrounding (sic), I called the DON and the Administrator to notify them. Most of the night staff went about searching for the resident until he was found at 6:50 AM. The review also revealed the Responsible Party was contacted and CR #1 was provided with a wanderguard. Record review of physician's orders [REDACTED].#1 revealed the following order: Place wanderguard on right ankle and watch its functioning every shift for Wandering/Elopement. Interview on [DATE]0/20 at 10:30 AM with the DON revealed they did not report to HHSC when CR #1 was located in the area by staff. When questioned as to the reason it was not reported she stated the resident was found in the area a short time later. Record review of the Provider Letter 19-17 for Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to HHSC dated 7/10/19 revealed nursing facilities must report a missing resident within 24 hours.

F 0660

Level of harm - Immediate jeopardy

Residents Affected - Few

Plan the resident's discharge to meet the resident's goals and needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the prepartion of residents to be active partners and effectively transition them to post-discharge care for 1 of 4 residents (CR #1) reviewed for discharge process. The facility failed to ensure CR #1 was provided effective discharge planning when he discharged , per administration's directive, on the same day he eloped and was found off facility premises. CR #1 was discharged to a private apartment without staff arranging the medical care services of a Home Health Agency to monitor his blood sugars and wound care, without providing CR#1's physician ordered medications and administration instructions and without providing wound care instructions and supplies. CR#1 was found alone in his apartment, deceased lying on the floor six days after being discharged from the facility. Medications were found in the apartment that belonged to another resident who resided at the discharging facility. Upon recognition of the medication error, the facility failed to ensure the wrong medications were retrieved, and the correct medications were provided. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continued to monitor the effectiveness of the Plan of Removal. This failure could affect any resident in the facility and placed them at risk of improper discharge, unmet needs, injury and death. Findings include: CR #1 Record review of CR #1's face sheet revealed the 61year-old resident was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of hospital records dated [DATE] revealed CR #1 had been transferred to the hospital after having being found unconscious in his apartment with a blood sugar reading of 700. (Normal blood sugar levels range from 70- 140). Record review of CR #1's H & P conducted by the physician on [DATE] read in part. [MED]-dependent but non-compliant with medications.recent orthodontic surgery with removal of teeth.Patient is seen today for evaluation and management of uncontrolled diabetes.sacral wound .wakes easily to name, and responds with ,[DATE] word remarks that are appropriate to conversation. He engages with provider, makes his needs known but is not able to give a reliable history of his health or hospitalization .previously ambulatory with walker.unsteady gait. appears catchetic and frail.sacral wound reported patient did not allow inspection. Record review of the admission MDS with an ARD of [DATE] revealed CR #1 scored an 8 on the BI[CONDITION] indicating he had moderate cognitive impairment. The review further revealed the resident required 2 person assist for bed mobility, hygiene and transfers and that he required only set up assistance for ambulation. The review further revealed the resident had demonstrated verbal behaviors towards others and that he did not require the use of a wheelchair, walker or other assistive ambulatory device. The review revealed the resident was frequently incontinent of both bowel and bladder. Record review of physician's orders [REDACTED].#1 revealed the following orders: [MED] [MEDICATION NAME] Solution [LOC]/ml Inject 10 unit subcutaneously at bedtime Hold for BS <150, for type 2 diabetes mellitus with diabetic [MEDICAL CONDITION]. [MED] [MEDICATION NAME] Solution 100 Unit/ML Inject 30 unit subcutaneously in the morning Hold for BS < 150, for diabetes mellitus with diabetic [MEDICAL CONDITION]. [MED] KWIK Pen Solution Pen-Injector [LOC]/ML ([MED] [MEDICATION NAME]) Inject as per sliding scale: If ,[DATE]=5 units, ,[DATE]=7 unit; ,[DATE]=9 units; ,[DATE] = 11 units Call MD if BS < 70 or >400, subcutaneously before meals, for type 2 diabetes mellitus with diabetic kidney disease. FSBS q am before meals Notify MD of BS <60 or >300, for diabetes management. FSBS q am in the morning Notify MD of BS<60 or >300, for diabetes management. License nurse to monitor: Sacral pressure: for any abnormalities or changes to surrounding skin q shift. Ensure dressing is intact. Document plus sign for no observed changes and a minus sign for any observed changes and notify MD and document findings every shift for monitoring, (for sacral wound management). Sacral unstageable wound .Cleanse with NS/WC, apply santyl/aginate and cover with dry absorptive dressing every day shift for unstageable wound. [MED] Tablet 10 mg Give 1 tablet by mouth at bedtime, for hypertension. [MEDICATION NAME] Tablet 20 mg Give 1 tablet one time a day, for gastro-[MEDICAL CONDITION] reflux disease. [MEDICATION NAME] (rDNA) Kit 1 mg Inject 1 ml intramuscularly every 1 hours as needed for 1ml IM prn BS less than 60 if patient unable to swallow, for diabetes mellitus with ketoacidodosis without coma. [MEDICATION NAME] [MED] Tablet 50 mg Give 2 tablets one time a day Hold for SBP <110 or P< 60. Give 2 tablets total dose, for hypertension. [MEDICATION NAME] Tablet 50 mg Give 1 tablet every 12 hours Hold for SBP < 110 or Pulse < 60, for hypertension. Senna Tablet 8.6 mg Give 2 tablets by mouth every 24 hours as needed for constipation QHS prn. [MEDICATION NAME] [MED] Tablet 100 mg Give 1 tablet by mouth one time a day, for [MEDICAL CONDITION] with acute exacerbation. Record review of CR #1's nursing notes dated [DATE] completed by the wound nurse read , Received no documentation concerning the wound from the hospital. The review revealed the wound nurse contacted the hospital but they could not provide documentation regarding CR #1's wound. The wound nurse documented, Wound is currently unstageable with white tissue covering the base. Wound care doctor to eval. Treatment orders in place. Record review of CR #1's nurses' note dated [DATE] revealed the resident succeeded in exiting the facility unaccompanied and was found in the parking lot at the facility. Record review of CR #1's nurses' note dated [DATE] read in part, .At 5:20 AM.my attention was drawn that resident has left the facility unaccompanied and unauthorized. After a search of the nearby surrounding (sic), I called the DON and the Administrator to notify them. Most of the night staff went about searching for the resident until he was found at 6:50AM. The review also revealed the Responsible Party was contacted and the resident was provided with a wanderguard. Record review of Social Services notes dated [DATE] 08:40 am written by the facility's social worker revealed the DON informed her that CR #1 was to be discharged to either of 2 named skilled nursing facilities each with a secure unit. Record review of Social Services notes dated [DATE] 09:12am read, Resident's RP/(family member) stated that she wants to take resident home with home health. Record review of CR #1's nursing notes dated [DATE] 10:56 AM written by the ADON read, Spoke with this residents RP about his recent elopement attempts. She was made aware tht (sic) this resident was not hurt and was easily retrieved back to the facility. She was also made aware that he needed to be safer at a secure unit and this company had several to choose from. She said no to that idea and that she would prefer to get home health and take him home. I said that would be fine but it needs to happen today. So the SW was notified and spoke to the RP as well. We will continue to monitor this situation. Resident is safe and secure in his room at this time. He is in bed with the covers pulled p (sic) over his head. Record review of CR #1's nursing notes dated [DATE] 4:29pm written by the ADON read, Resident was discharged home with his RP. (family member) verbalized understanding of how to admisister (sic) medications to him. His vital signs at the time of his departure were ,[DATE] (blood pressure). and O2 sat 99% on room air. Record review of physician's orders [REDACTED].#1 revealed the following orders: D/C home with medications. Home Health Nursing Services Order date [DATE]. Place wanderguard on right ankle and watch its functioning every shift for Wandering/Elopement- Order Date [DATE]. Record review of CR #1's nursing notes dated [DATE] 8:59pm written by the ADON read, On [DATE]st, order received for resident to be discharged to home with home health. Resident's (RP) was made aware of pending discharge. Sw made aware to set up home health services. Per the Sw, resident left the building with his (family member) and didn't have his medications. The SW states that she called the (family member) to come back to come pick up the medications. She in-turn told the Med Aide to bag up his meds for discharge. Later he came with the medications in a plastic bag and gave them to me. The Rp returned and was standing at the door, so I gave her the package and asked her if she was familiar with his medications or did she have a question about how to administer them? She responded no that she'd given them before and she understood how to give them. She took the medications and left. About 30 minutes later the med aide said that he needed the package of meds back because he'd given the wrong residents meds. The charge nurse was informed and he called leaving a voice message. I called twice and got her the second time. I apologized for the inconvenience and asked her to bring the medications back. I informed her that a mistake had been made and she'd been given the wrong medications. She moaned about it a little bit but promised to bring them back. The evening charge nurse was instructed to look out for her return as she was to bring the meds back to us. Record review of the Discharge Plan and Summary dated [DATE] revealed CR #1 was going home with home health. Two family members were listed as available to help resident. The question relative to resident's level of consciousness/cognition was answered by a check by Intermittent confusion or fluctuations in consciousness. Record review of the document entitled, Physician Discharge Summary dated [DATE] read in part, .Final [DIAGNOSES REDACTED].He remained confused during stay mainly oriented to self, sometimes place, never time.patient discharged home. A telephone interview was conducted with CR #1's Nurse Practitioner on [DATE] at 1:30 PM. She stated she did not discharge him as he was not ready to discharge. She stated she was surprised to learn he had been discharged and believes the physician would agree with her. She stated the plan was for CR #1 to eventually transfer to a Personal Care Home as he required someone to take care of his medications. She stated CR #1 did not have the capability of managing his medications and required someone to do so. With regard to his ambulatory capacity she stated the resident could walk but had an unsteady gait and was somewhat frail. Record review of an Internal Investigation and Attestation dated [DATE], revealed the document was type-written and was a synopsis of questions from a regional operations employee posed to the social worker. The review further revealed the social worker having stated she sent referrals to 2 separate home health agencies. The review revealed that Home Health Agency #1 accepted CR #1 on [DATE] and that Home Health agency #2 did not accept the resident because they required a signature from the physician. According to the document the Social Worker contacted Home Health Agency #1 on [DATE] and she was advised the agency could not work with the resident due to his insurance. The review further revealed that the Social Worker also contacted Home Health Agency #2 which had denied services on [DATE] and the Social Worker was informed the agency could not work with the resident due to his insurance. The document also read, in part, .No other insurance companies were contacted and (family member) was left voicemails to attempt to notify her. Social Worker was unable to document on the resident's chart the above attempts. The review also revealed that the Social Worker did not inform the DON nor the Administrator of the information obtained. The Social Worker initialed this document. Record review of Social Services Progress Notes dated March and [DATE] revealed no documentation of home health agencies being contacted or clinicals having been sent to home health agencies. A telephone interview was conducted on [DATE] at 9:00 PM with the facility's social worker. The social worker stated that she learned in the early morning staff meeting on [DATE] that CR #1 had eloped and the facility's administration did not want him to remain at the facility. She stated the ADON called the family and she herself attempted to set up home health for the resident. She stated that home health services with Home Health Care Agency #1 were pending due to the agency requiring a script signature from the doctor. She stated the other agency did not accept the resident but the resident was pending with the other agency. The social worker further stated that the Administrator and the DON wanted him gone. She stated she was told to get the Medication Aide to bag up the prescriptions which she did. She stated she recalled the resident and knew that he lived alone. She further stated she sent both home health agencies fax sheet, face sheet, medication list, doctor's documentation notes and thought she did so on [DATE]. She stated she was absent on [DATE]st and 2nd and she was terminated on the 8th. A telephone interview was conducted on [DATE] at 11:00 AM with an employee of Home Health Agency #1. The employee stated that the facility's social worker called them 2 days in a row. She stated that the second day the social worker called, the social worker had to be reminded that she had already been informed the agency could not accept the resident due to insurance. She stated that the referral was received by the agency on [DATE] and the social worker called them the following day questioning the agency refusing the resident's Medicaid coverage. The agency employee stated the coverage did not extend to skilled nursing assistance which the resident required. A telephone interview was conducted on [DATE] at 12:00 Noon with Home Health Agency #2. The employee from the agency stated they received clinicals from the social worker on [DATE] but they could not accept the resident as there was no signed physician's orders [REDACTED]. Record review of the document entitled Internal Investigation Statement and Attestation dated [DATE] regarding the statement provided to the

Corporate Officer by the Medication Aide was reviewed. The document read that the following medications were erroneously sent home with the resident and his family member [MED], [MED], [MEDICATION NAME], [MED], [MEDICATION NAME], [MED], [MEDICATION NAME] and [MED]. A telephone interview was conducted on [DATE] at 2:00 PM with the Medication Aide. He stated that the facility's social worker came to him on [DATE] and asked him to prepare a resident's medications as he was being discharged . He stated she stated Mr. (NAME REDACTED) the surname of Resident #2. He stated he went to Resident #2, who was alert and oriented, and asked him if he was discharging today and he replied that yes he was. He stated he went and prepared the bag of medications for Resident #2 and took it to the ADON. Later that day about 4:00 PM Resident #2 asked for his meds and was informed they were upfront. Resident #2 went to the front of the building requesting his meds and then came back and stated the ADON wanted to see him, (the Medication Aide). He stated he went up front and was asked whose medications were in the bag and he informed her they were Resident #2's medications. He further stated he was informed by the Charge Nurse on duty that CR #1's family member had been contacted and would bring the medications right back. Record review of the physician's orders [REDACTED].#2: Abiraterone Acetate tablet 250 mg for malignantneoplasm of prostate. Bicalutamide Tablet 50 mg for malignant neoplasm of of prostate. [MEDICATION NAME] Tablet 5 mg for malignant neoplasm of prostate. [MED] [MED] Capsule 0.4mg for malignant neoplasm of prostate. [MEDICATION NAME] ER Tablet 30 mg for pain. [MEDICATION NAME] [MED] Tablet 50 mg for pain. [MED] Tablet 80 mg for [MEDICAL CONDITION]. [MEDICATION NAME] Tablet 10 mg for muscle spasm. [MED] Capsule 200 mg for cough. [MEDICATION NAME] [MED] Tablet 10 mg (a muscle relaxant). [MEDICATION NAME] Capsule 100 mg for [MEDICAL CONDITION]. [MED] Tablet 50 mg for hypertension. [MEDICATION NAME] ER Tablet 24 hour 90 mg for hypertension. A telephone interview was conducted with the former ADON on [DATE] at 4:06 PM. She stated that CR #1 eloped early on the morning of [DATE] and this was the resident's second attempt. They wanted the resident to be in a secure unit or somewhere safer. The Responsible Party offered to take the resident home. Following his discharge she realized his medications were not sent with him. She spoke to the Medication Aide and informed him to get the medications ready to go. She stated she herself was seated in the front at the desk monitoring the entrance when the family member came and she gave the bag of medications to her. She stated she asked the family member if she had any questions about the medications and she replied she did not. She stated she did not see a medication list with the medications. She stated a short time later the Medication Aide returned and asked for the medications back as they were medications belonging to another resident with a similar name. She stated she called the family member and apologized asking her to please return them to the facility and exchange them for the correct medications. She stated that the Charge Nurse called the family member but there was no answer. She stated she instructed the Charge Nurse to look out for the family member and she herself left for the day. She stated she thought the issue was taken care of. A telephone interview was conducted on [DATE] at 2:00 PM with Charge Nurse B. He stated he was not present at the facility at the time of the incident and stated he was at home. He further stated no one informed him to contact the family of CR #1 regarding medications. Interview on [DATE] at 9:30 AM with the DON revealed that a medication inventory list should have been sent with the resident's medications. She further stated that the facility does not send narcotics with the resident at the time of discharge. She said narcotics have to be ordered from a pharmacy that is convenient to the family/resident. She further stated that had she been informed that the wrong medications had been sent with the resident, she herself would have delivered the correct medications and retrieved those of Resident #2. A telephone interview was conducted on [DATE] at 4:58 PM with Wound Nurse C. Wound Nurse C stated she was familiar with CR #1's sacral wound. She stated it was still unstageable but getting better. She stated she was one of 2 wound care nurses. Both do work together and in CR #1's case, he was often resistant to care to have the cream applied and the dressing changed but they were able to work with him to get him to cooperate. A telephone interview was conducted on [DATE] at 5:05 PM with Wound Care Nurse D. Wound Care Nurse D stated the wound was unstageable but looked like it was closing up a bit and was looking better. She stated the resident was often uncooperative. They could perform wound care-changing the dressing and applying the cream very easily if he was asleep but frequently it took the 2 of them up to 30 minutes to redirect him into cooperating. She stated she was surprised to learn that the resident had discharged on [DATE]st without wound care instructions. She was told by the ADON that the family was returning for medications so she placed wound care instructions in the bag. A telephone interview was conducted on [DATE] at 1:50 PM with CR #1's Responsible Party (RP). RP stated that she was contacted by the facility on [DATE] and informed that her CR #1 had left the facility. She stated he walked almost to the freeway, a distance of 5 to 6 miles from the facility. She stated the facility told her he had to be discharged or they were going to place him in a secure unit. She further stated she did not feel he needed to be in a secure unit as he lived by himself. She was told that if she was coming to get him she had to be at the facility by 2:00 PM. She stated she picked CR #1 up and the Social Worker gave her 2 numbers for home health agencies but no one ever called. She stated she went back to pick up his medications and then received messages that they were the wrong medications. She stated she asked CR #1 who insisted the medications were correct and so she did not go pick up the other bag of medications. When asked about CR #1 living alone, She stated that she paid a resident who lives on the same hall to knock on his door and check on him each morning. She stated she did have family to help take care of him but he wanted to go back to his own apartment as he was used to living alone. She stated that she got a call from the neighbor one day at which time he informed her CR #1 was on the floor. She stated that she advised him to call 911. The police then informed her he had passed away. She stated the bag she was given contained a lot of medications and was heavy. She stated one of the medications was a muscle relaxant. She wonders if CR #1 took the wrong medications and this is what caused him to pass away. She further stated this is not right and my (family member) should be here today. Interview on [DATE] at 9:45 AM with the Administrator and the DON revealed they first learned of the resident's demise from a phone call from the police on [DATE]. Both the DON and the Administrator stated the police requested medication records which they provided. The Administrator stated that they turned in a self-report to the State Agency and initiated an internal investigation at that time. The Administrator stated they terminated the employment of the ADON and also of the Social Worker. The DON stated they were informed the Social Worker instructed the Medication Aide to get the medications for a resident using Mr. (NAME REDACTED) CR #1's surname. The Med Aide got the medications together and gave them to the ADON. CR #1 had already left with his family member when they realized the medications had not been sent with the resident and the family member so she was contacted and returned to get the medications. The medications provided were those of Resident #2 whose first name is the same as CR #1's surname. The DON stated that to the best of her knowledge no itemized medication list was provided with the medications that were given to the family member of CR #1. The DON stated that if someone had informed her the wrong medications were given to the family, she herself would have gone to retrieve the incorrect medications and deliver the correct ones. The Administrator stated that the facility's social worker who is responsible for planning a safe and orderly discharge for residents, failed to complete the home health referrals and did not document her efforts in the chart. An interview was conducted on [DATE] at 11:45am with the DON. At that time CR #1's elopement attempts were reviewed. The DON stated that CR #1 was exit seeking. They were concerned he would leave the facility overnight as he had early that one morning. She stated it was felt the resident would be better placed at a secure unit. She further stated they could not take the risk CR #1 would elope during the night. She further stated the RP did not want CR #1 to be transferred and she preferred to take CR #1 home with home health care services. A telephone interview was conducted on [DATE] at 9:00 PM with HPD Officer who arrived on the scene of CR #1's apartment when summoned by the 911 call. He stated CR #1 was pronounced deceased at the scene at his apartment where he resided alone. The HPD Officer responded to questions regarding medications found in the apartment. He stated that medications discovered and bagged up and taken were medications with the names of both CR #1 and Resident #2. Record review of the written policy entitled Transfer & Discharge Procedure Operations , read in part, Transfer and discharge procedures must provide sufficient preparation and orientation of the resident to ensure a safe, orderly transfer or discharge from the facility.Discharge indicated movement of a resident to a non-institutional setting, such as home, without expectation of return.The Interdisciplinary Team (IDT) should evaluate the resident's discharge potential based on a clinical assessment of the resident's status.Preparation and Orientation includes.orienting resident's caregivers .to resident's daily patterns .the physician provides a discharge order. Review of the written policy entitled, Resident Discharge with Medications read in part, 1.An order is obtained from the resident's physician to discharge or transfer the resident with all medications where permissable by State Law. 2. The resident is evaluated by the licensed nurse and the Interdisciplinary Team (IDT) to determine if the resident is able to properly store and self-administer ordered medications. 3. If the resident is unable to self-administer medications, an authorized caregiver will assume responsibility of the resident's medications at the time of transfer or discharge and must sign the Post Discharge Plan of Care (Briggs). 4. Medications released to the resident or resident caregivers are documented. On [DATE] at 11:50 AM, the Administrator and the DON were notified of Immediate Jeopardy (IJ) and an IJ Template was provided. A Plan of Removal was requested at that time. The final plan of removal was accepted on [DATE] at 2:33 PM after revisions were made. The Plan of Removal included the following: Plan to Remove Immediate Jeopardy [LOC] [DATE] Admission/Transfer/Discharge Pasadena Care Healthcare Center respectfully submits this plan of removal to abate the allegations of Immediate Jeopardy identified on [DATE] for Admissions/Transfer/Discharge. Immediate Action: -In-services were immediately initiated on [DATE] and completed on [DATE] by 7:00 PM by the Director of Nursing on the following topics to include transfer and discharge procedures, residents discharging home with medications, name alerts, medication reconciliation, (cross reference0, medication pass verification, resident discharge audit. All licensed nurses and Medication Aides were educated on the following and completed on [DATE] by 7:00 pm. Discharge Process: On [DATE] a discharge review was completed for all residents discharged in the past 30 days to ensure that home health care services was in place at the time of discharge. On [DATE] the facility completed an Ad Hoc Quality Assurance Meeting (4 point plan) conducted by the District Director of Clinical Services. meeting participants included the Interdisciplinary Team Members; Administrator, Director of Nursing, Medical Director, MDS Coordinator and Unit Managers. On [DATE] and ongoing the Director of Nurses/Designee review discharges from prior day to include family notification, physician notification, discharge order(s), discharge nurse notes, and medication reconciliation. On [DATE] the Nurse responsible for failing to ensure reconciliation of medications was suspended pending investigation. This nurse was terminated on [DATE] for failure to follow facility discharge policy. On [DATE] the Social Worker was terminated for failure to follow discharge policy related to verification of home health care services. Beginning [DATE] and ongoing for the next 30 days the Director of Nursing or designee will review the Interdisciplinary Team including the Administrator during the daily stand down meetings residents who have been discharged have the following completed: Verification of Home Health Care Services Verification that residents received the correct medications @ the time of discharge Verifications and cross checking of residents names Medication Reconcilation Verification of safe discharge location/environment On [DATE] Licensed Nurse and Medication Aides were re-educated by the Director of Nursing on the following topics to include transfer and discharge procedures of residents discharging home with medications, name alerts, medication reconciliation, (cross reference) medication pass verification, resident discharge audit. This will be completed by [DATE] by 2:00 pm. On [DATE] The Director of Nursing or designee Educated Licensed Nurses on the facility's policy on Transfer and Discharge Procedure to include Emergency Discharge and Family/Resident Education. This will be completed by [DATE] by 2:00 pm. On [DATE] and ongoing for the next 30 days the Director of Nursing or designee will Audit Resident discharged to home to include the following: Resident's Name discharge date Family Education/Training Discharge Location Physician Notification Administrator/Director of Nursing Notification Medications Reconciliation On [DATE] The Administrator Educated the Director of Nursing, Unit Manager, and other nurse managers on the process of referring home health services, as well as DME's, (sic), and other referrals to ensure safe discharge in the absence of the Social Worker. The Unit Manager will be responsible for arranging home health services in the absence of Social Worker. This process will be verified by the Director of Nursing and Reviewed by the Administrator Monitoring included: Record review was conducted of the facility's in-services that had been conducted. The review revealed that the facility initiated in-service education of

	staff on [DATE] and completed in-services on [DATE]. Documentation of the following in service topics were reviewed: Resident Discharge conducted by DON on [DATE]. Transfer and Discharge conducted by DON on [DATE]. Transfer and Discharge Procedure conducted by the DON on [DATE] Emergency Discharge Procedure: conducted by the DON on [DATE] Resident Discharge with Medication conducted by DON on [DATE]. Family /Resident Education conducted by the DON on [DATE] Name Alert conducted by DON on [DATE] and on [DATE] Resident Discharging Home with Medications conducted by DON on [DATE]. Documentation conducted by DON on [DATE]. Resident Discharge Audit conducted by DON on [DATE]. Medication Reconciliation with Resident Discharge conducted by DON on [DATE]. Medication Checks & The 8 Rights conducted by DON by on [DATE]. Record review of the Written Policies and Procedures utilized in the in-services were reviewed. These are: Documentation Operations 4 Clinical Operations Chapter Nursing Operations. Resident Discharge with Medications Operations 4: Clinical Operations Chapter Pharmacy Operations. Social Service Program Operations 4: Clinical Operations Chapter Social Service Operations. Omnicare LTC Facility Pharmacy Services and Procedures Manual Policy #/Title 7.4 Leave of Absence, Resident Discharge with Medication or Other Change of Status. Record review of the document entitled Release of Responsibility For Medication, an itemized list of medications to be utilized in situations of leave or absence or discharge from facility, which was used in the in-service training was reviewed. Record review was also conducted of the facility's internal audit of a resident discharging home on [DATE]. The review revealed that issues including but not limi

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

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.