STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIA CHRISTI VILLAGE - HAYS INC	**2225 CANTERBURY DR HAYS, KS 67601**

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 88 residents, with one reviewed for involuntary discharge. Based on interview and record review, the facility failed to provide Resident (R) 1 to with an appropriate involuntary discharge notice. The facility failed to document an appropriate reason for the resident's discharge, failed to obtain a discharge order from the resident's physician, and failed to find a new facility to meet the resident's needs. Findings included: - R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The Discharge Planning Care Plan, dated 02/25/2020, documented the resident appointed his family member as his Durable Power of Attorney (DPOA) for health care, had no plans for discharge at that time. The care plan documented the facility was in the process of issuing a 30-day discharge notice. The care plan documented the 30-day involuntary discharge notice was provided to the resident and his DPOA on 12/31/2019. The Fax to Physician, date 11/21/19, documented the facility was no longer able to meet the resident's needs and was issuing a 30 involuntary discharge notice to the resident. On 03/10/2020 at 08:50 AM, Administrative Staff A stated Social Services had reached out to 48 facilities, only three have responded requesting more information but they all have denied the resident. On 03/10/2020 at 11:37 AM, Administrative Staff A stated Administrative Staff B talked to R1's DPOA about the resident being discharged to the DPOA's residence, but the DPOA was not in agreement with the resident coming to her residence. The DPOA was told that as long as she was working with staff to find placement for the resident the facility will not discharge the resident. On 03/11/2020 at 02:04 PM, Administrative Staff B stated the facility did not have an order from the physician to discharge the resident. Administrative Staff B stated the facility did not have a new facility for the resident to go to but continued to look for one. The facility's Clinical Protocol: Transfer or Discharge Documentation policy, dated December 2019, documented when a resident is transferred or discharged from the facility, the following information will be documented in the medical record: 1. The basis for the transfer or discharge; a. If the resident is being transferred or discharged because his or her needs cannot be met at the facility, document will include: i. The specific resident needs that cannot be met; ii. This facility's attempt to meet those needs; and iii. The receiving facility's service(s) that are available to meet those needs. 2. That an appropriate notice was provided to the resident and/or legal representative; 3. The date and time of the transfer or discharge; 4. The new location of the resident; 5. The mode of transportation; 6. A summary of the resident's overall medical, physical, and mental condition; 7. Disposition of personal effects; 8. Disposition of medications; 9. Others as appropriate or necessary; and 10. The signature of the person recording the data in the medical record. The facility failed to ensure the resident's clinical record included documentation of an appropriate reason for R1's discharge, failed to obtain a discharge order from the resident's physician, and failed to find a new facility to meet the resident's needs.

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.