STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106042	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FREEDOM SQUARE REHABILITATION & NURSING SERVICES	**10801 JOHNSON BLVD SEMINOLE, FL 33772**

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 0660 **Level of harm** - Minimal harm or potential for actual harm **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 record review and interviews, the facility failed to ensure that it developed an accurate and effective discharge plan with timely arrangement of support services, home health, for one (#2) of seven sampled residents. Findings included: A review of Resident #2's medical record, the Admission Record, documented an admission of 08/11/20 from a local hospital. The [DIAGNOSES REDACTED]., adult failure to thrive, history of falling, [MEDICAL CONDITION] disorder, [MEDICAL CONDITION], and muscle weakness. A review of Resident #2's care plan, documented a focus area of: (Resident #2) wishes to return to his home, initiated on 08/13/20. Goal: (Resident #2's) discharge goals are: build strength and DL skills to improve independence, initiated 08/13/20. Interventions included: Establish a pre-discharge plan with the (Resident #2) /family/caregivers and evaluate progress and revise plan, initiated 8/13/20; Make arrangements with required community resources to support independence post-discharge (specify home care, PT, OT, MD, Wound Nurse for (Resident #2.)); Provide discharge teaching, initiated 08/13/20. A review of the facility discharge log documented that Resident #2 discharged home on[DATE]. A review of Resident #2's Progress Notes, dated 09/02/20, 15:50 (3:50 p.m.), Social Service: (Resident #2) is alert, oriented and can make his needs known. He is scheduled to d/c (discharge) home on 09/02, he stated that he has Hospice services in place once he has d/c home. Resident #2 has all DME (Durable Medical Equipment) needed at home and will d/c with (Hospice Provider) Hospice. On 10/15/20 at 9:40 a.m., a phone interview was conducted with a representative from Family Services. She stated that she had been following Resident #2 and that Resident #2's primary physician was involved with getting the resident admitted to the nursing facility. She stated that she had contacted the facility and spoke with Staff A, Social Services (SS), sent her a release, and voiced to Staff A that the resident was to be a Long-Term placement. The Family Services Representative (FSR) stated that she was conducting a follow up on 09/10/20, she called and spoke with Staff A who informed her that Resident #2 had been discharged and that a referral to Hospice had been conducted for the resident. The FSR stated that this did not make sense, the resident did not have a terminal diagnosis. Then, I called the resident and he did not pick up. I then called the neighbor of Resident #2. He got a message over to Resident #2. I called hospice while I was waiting on a return call from Resident #2. I spoke with a Hospice LPN (Licensed Practical Nurse). She stated that hospice had just received a referral (09/10/20); the resident was unknown to them. The FSR stated that this referral was done on 09/10, not on 09/02, the day that the resident was discharged ; and it was done after my conversation with the social worker. The next day, the resident called me. He stated that he was discharged home with no home health. I called (Facility), talked to the social worker. The ADON (Assistant Director of Nursing) and DON (Director of Nursing) were involved, the ADON said they could take him back, it had been less than 30 days. Then, the Nursing Home Administrator (NHA) called me, he said that they could take him back, but there was a problem, that the quarantine unit was full. The resident would have to wait for an opening. He stated that if that did not work out, he could make a referral to one of the area sister facilities. Then, I went back out to see (Resident #2) (at his home); The resident refused to return to the nursing home; he was not interested in going back. He signed a release in regard to our involvement. Then, the next day, the NHA called. He stated that they had referred a home health (HH) agency, that HH had gone out to the resident's home and the resident had accepted the HH services. The FSR stated, 09/24/20 is when she received the voicemail from the NHA about (HH Company) and the resident accepting the services. On 10/15/20 at approximately 1:45 p.m., an interview was conducted with Staff A, SS. She stated that she did not make a referral to hospice at the time of discharge. She stated that she did call hospice and found out that the services were actually for the resident's significant other. She stated at that time, I followed up with getting services for home health, (HH Company Name), for the resident. Staff A was asked if it was a week after the resident's discharge and Staff A responded, Could possibly be. Staff A was asked if she documented this in the clinical chart and Staff A responded, No. On 10/15/20 at 5:25 p.m. a phone interview was conducted with the Medical Doctor (MD) that saw Resident #2 while he was in the nursing facility. She stated, if I (MD) remember correctly, the resident had a significant other that passed away. When asked if the resident was on hospice the MD responded, Do not think he had hospice. When I look at my notes, he was going home with PT (physical therapy), OT (occupational therapy), nursing; I was reading the notes, he looked much better, that note was dated 08/27/20.' The MD said then, he was to follow with (insurance company)and his primary physician; I wrote down why he needed PT, OT, and skilled nursing care. A review of Resident #2's clinical chart, Physician Notes, dated 08/27/20, documented: Home Health: Patient requires physical therapy for gait training, strengthening, endurance, balance, fall prevention and safety. Patient requires occupational therapy for: ADL (Activities of Daily Living) training/retraining, fall prevention and safety, pain management, strengthening, energy conservation. Patient requires skilled nursing for teaching and training medication regimen and coordination of care. A review of the facility policy and procedure titled, Discharge Planning, LCS2017, page 106, documented the standard: The Community establishes a formal discharge planning process at the time the resident is admitted . The discharge planning is an interdisciplinary process and complies with all State and Federal Laws and regulations. Purpose: To ensure that each resident admitted to the health center has a planned program of treatment, including nursing and therapy services which is designed to return the resident to his/her highest level of functioning. Page 107, Sample Discharge Plan Policy & Procedure: Policy: The Social Service Director, Nurse Navigator, or designee serves as the Discharge Planning Coordinator to interpret the medical and social needs of the resident and collaborate with other professional staff in estimating discharge planning. The Guideline included: 5. It is the responsibility of the Discharge Planning Coordinator to assist the resident and/or legal resident representative in the development of, planning of, and implementation of a discharge plan .6. It is the responsibility of the Discharge Planning Coordinator to ensure the completed discharge plan will be part of the resident clinical record .8. The Discharge Planning Coordinator will ensure that an appropriate after care representative (e.g. Hospice, Home Health) is involved in an appropriate time frame to ensure a smooth and safe transition home.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure medical records were accurately documented for three (#2, #3, #4) of seven residents in regard to pre-dating a Nursing Home Transfer and Discharge Notices (#2, #3); Completion of a Discharge Notification order by non-nursing staff (#2, #3, #4); and non- documentation of case manager involvement with a resident (#2). Findings included: 1. A review of Resident #2's medical chart, the Admission Record, documented that he admitted to the facility on [DATE]. Further review of Resident #2's chart reflected that the resident discharged from the facility on 09/02/20. A review of Resident #2's Nursing Home Transfer and Discharge Notice, dated as given on 08/11/20 with an effective date of 09/02/20, documented the location to which the resident is transferred or discharged as Home

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with an address. Review of the form identified no reason for discharge or transfer. The notice was documented to have been presented to the resident on 08/11/20. The notice was signed by Resident #2, but his signature was not dated. An interview conducted with Staff A, Social Services (SS), was conducted on 10/15/20 at approximately 1:50 p.m. regarding the form. She stated that usually they come in, we discuss this notice. She was asked if the resident signs the notice at the time of admission. She stated Sometimes, yes. She confirmed that she prepares the notice. She stated that the effective date is the discharge date . We do not know the effective date until the discharge. When asked what the reason was for Resident #2's discharge, Staff A, SS, stated, the resident received a Last Covered Day (LCD) notice and he discharged (d/c) home. Usually, the resident d/c's after the LCD. Staff A, SS confirmed that the reason her signature was dated 08/11/20 was because that was the date the notice was discussed with the resident. A review of a Discharge Notification, dated 08/25/20, reflected Resident #2's name, discharge date of [DATE], discharge placement of home with an address. Medication Needed: D/C home with remaining meds, including narcotics. Home Health Agency: Name of Hospice Provider. The areas for PT (Physical Therapy), OT (Occupational Therapy), and Nursing had Xs present on the line. The form had the physician signature with a date of 08/27/20. At approximately 1:50 p.m., the Discharge Notification form for Resident #2 was reviewed with Staff A, SS. Staff A stated that she filled out the top of the form, that it is filled out before the discharge. She confirmed the top part of the form was completed on 08/25/20. She stated that she did not put the X in the form on the PT; the OT, Nursing. She stated that she usually uses a check mark. She stated that Resident #2 stated he had hospice at home. A review of Resident #2's clinical chart, Social Services Progress Note, dated 08/27/20, documented: (Resident #2) is alert, oriented and make his needs known. He plans to discharge home when able. SW was contacted by Agency case manager who states she is following (Resident #2). She provided the facility with a copy of confidential information release form signed by (Resident #2). Further review of Resident #2's record reflected no other mention of the case worker's involvement or purpose of the communication. At approximately 1:50 p.m., Staff A, SS stated that she could not recall the reason for the case worker's call about Resident #2. At 2:42 p.m., an interview was conducted with the Director of Nursing regarding the Discharge Notification form. She stated that it was a notification, it is a request. She confirmed that it was a facility request to the doctor to get an order for [REDACTED]. She confirmed the name of Agency representative. Staff A, SS, stated that she did not recall all the words that we spoke about, but that she was one of the people following (Resident #2). When asked if she documented anything in the clinical chart about why Agency was following the resident, Staff A said that She (Agency Representative) sent me over a consent, that allowed access to the chart. I guess what happened is that I took his word about the hospice services; he was always alert to place time and date. No red flags. Staff A said that Agency Representative was calling because they were recommending that the Patient stay here; when I talked to the resident, he wanted to go home. Staff A could not recall why the case worker was recommending the resident to stay in facility. Staff A stated, I contacted hospice on the 10th, I followed up; they said that hospice services were not in place. His significant other had hospice. So, I sent out a hospice referral on 09/10; also, a referral for home health, on 09/10. Staff A stated that she called the resident; home health talked to him on the 10th, and hospice said that they went out as well. On 10/15/20 at 5:25 p.m. a phone interview was conducted with the Medical Doctor (MD) that saw Resident #2 while he was in the nursing facility. She stated, if I (MD) remember correctly, the resident had a significant other that passed away. When asked if the resident was on hospice the MD responded, Do not think he had Hospice. When I look at my notes, he was going home with PT (physical therapy), OT (occupational therapy), nursing; I was reading the notes, he looked much better, that note was dated 08/27/20.' The MD said then, he was to follow with (insurance company)and his primary physician; I wrote down why he needed PT, OT, and skilled nursing care. 2. A review of Resident #3's medical record, the Admission Record, documented an admission of 08/25/20. Further review of the medical record documented that the resident discharged home on[DATE]. A review of Resident #3's Nursing Home Transfer and Discharge Notice, dated as given on 08/25/20 with an effective date of 09/29/20, documented that the resident was discharged home with an address listed. The reason for the discharge: Your health has improved sufficiently so that you no longer need the services provided by the facility. The form was signed by Staff A, SS on 08/25/20. The form was signed by the resident, 08/25/20. A review of Resident #3's Discharge Notification, dated 09/22/20, was reviewed with Staff A, SS at 1:52 p.m., she confirmed that she filled out the top portion, and that the physician signed the form on 09/22/20. 3. A review of Resident #4's medical record, the Admission Record, documented and admission of 10/01/20. Further review of the medical record documented that the resident discharged home on[DATE]. Review of Resident #4's chart reflected a Resident Request for Discharge form, signed by the resident on an unknown date. Review of Resident #4's Discharge Notification, dated 10/06/20, documented a discharge date of [DATE] with a discharge location of home and address. No physician signature was present on the form. At 1:28 p.m., an interview was conducted with Staff A, SS and she stated that Resident #4 requested to discharge home. She stated that if the resident wants to leave before the therapy is completed, I have them sign the form, Resident Request for Discharge. For the Discharge Notification,she stated, Well, you have to get the discharge order signed by the physician. When asked where the physician signature was for the discharge, she stated that sometimes the order is verbal.