STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366367	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTERCARE OF CANAL WINCHESTER POST-ACUTE RC	**6725 THRUSH DRIVE CANAL WINCHESTER, OH 43110**

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 review of the medical record, staff interview, and policy and review of the procedure for discharge planning, the facility failed to develop and implement an effective discharge planning process to ensure caregiver education and the capacity to perform required care, as well as ensure discharge instructions were complete with information needed to continue resident care at home. This affected three (Residents #200, #201, and #202) of three residents reviewed for discharge planning. Findings include: 1. Review of Resident #201's closed clinical record revealed an admission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The prescription was dated 08/21/2020 and did not include a discharge date . Review of the homegoing instructions/discharge summary revealed no evidence of what information that was provided to the responsible party at the time of discharge. There was no evidence of what medications that were given to the resident to take home or how much. The discharge summary indicated the family did take some medication home. There was no evidence of what medications were called in to the pharmacy for the resident to obtain after discharge. There was no evidence the resident/responsible party was provided information as to when the last dose of medication was taken or when the next doses were due to be administered. There was no evidence the resident was provided instructions/education on how to complete blood glucose monitoring, how to check blood pressure readings, how to use a Hoyer lift, or how to complete transfers. Review of the discharge care plan revealed discharge planning with a goal of assist resident/responsible party with decision making regarding discharge planning and resident will be discharged to a safe environment of choice. Interventions included make referral to community programs as indicated, but did not specify what community programs; meet with resident representative to discuss discharge location and identified service needs for discharge; and utilize available community resources for home going support (i.e. home care care). The care plan did not address what home health care agecy that was to be used upon discharge. The care plan did not address educational needs for the resident/responsible party, such as blood glucose monitoring, blood pressure monitoring, use of a Hoyer lift, transfers, and post-discharge needs with referrals to home health agencies with services needed and medical equipment. Interview on 08/26/2020 at 3:15 P.M. with Registered Nurse (RN) #1 revealed she had not completed any education with the daughter of the Resident #201 regarding taking blood pressures, completing blood sugar testing using a glucometer, using a Hoyer lift, or transfers. She stated before COVID-19 she would have did education but the families were not visiting at this time. Interview on 08/26/2020 at 3:55 P.M. with the rehab manager, Physical Therapy Assistant (PTA) #2 revealed the resident was cut by the insurance due to lack of progress. He stated he had little progress with little to no functional gain. He had been in a rehab facility prior to coming to this facility for a couple of weeks and had about 300 minutes a day while there. I let the family know they would need a Hoyer lift for transfers but stated he did not provide any education on how to use this equipment to transfer the resident. He stated he had advised the daughter to keep the resident here due to the level of care needed and apply for Medicaid but the daughter wanted to take him home. We had a care conference via phone a week into his stay with social services and therapy to discuss his needs. We do not do home assessments, only by request. We just usually don't do this. Due to Coronavirus this would have had to be done virtually. The daughter never expressed the need for training. Interview with RN #1 on 08/27/2020 at 11:17 A.M. revealed the resident's daughter called her on Monday and told her she didn't get the blood pressure equipment nor the blood sugar equipment, and the pharmacy told her they didn't get anything on it. RN #1 said she called it in Tuesday morning and she has not heard back from the resident's daughter. RN #1 siad she has not followed up with the resident's daughter since discharge. 2. Review of the medical record for Resident #200 revealed an admission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the discharge instructions/summary revealed there was no evidence the resident received information on when the last dose of medication was given prior to discharge, or when the next dose of medications were due to be given to the resident. The discharge summary did not include a list of medications to be taken after discharge and this area was left blank. 3. Review of the medical record for Resident #202 revealed an admission date of [DATE] at 7:40 P.M. with [DIAGNOSES REDACTED]. Review of the discharge instructions revealed no evidence the resident received information on when the last dose of medications was given or when the next dose of medications were due to be given to the resident. The discharge summary did not include medications to be taken after discharge and this area was left blank. Interview on 08/27/2020 at 11:17 A.M. with RN #1 revealed she agreed that all three residents reviewed did not have a medication sheet to go home with that stated when the medications were last given or when their next dose was to be given. She stated the nurses were supposed to complete this, and are trained to circle the next time the medication was due to be given, but this didn't occur in these cases. Interview with Pharmacist #3 from the facility pharmacy on 08/27/2020 at 4:15 P.M. revealed the facility should be documenting what medications were sent home with the resident and how much was sent. He said there was no policy on how that should be done. Review of the policy and procedure for discharge planning (undated) revealed the following: Policy: When a resident's discharge is anticipated, this facility will develop and implement a discharge plan that focuses on the resident's discharge goals, the preparation of the residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Procedure: Consider caregiver support person availability and the resident's or caregivers' support person capacity and capability to perform required care as part of the identification of discharge needs. Involved the resident and resident representative in the development of the discharge plan, address the resident's goals and treatment preferences. Discharge to the community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose. Discharge summary when a discharge is anticipated the facility will develop a discharge summary that includes, but is not limited to the following: Summary of stay, final summary available for release to include needs, strengths, goals, life history and preferences at the time of discharge that is available for release to authorized personnel and agencies with consent of the resident and/or representative. Medication reconciliation of all pre-discharge medications, with the resident's post-discharge medications, both prescribed and over the counter. Post-discharge plan of care will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow up care and any post discharge medical and non-medical services. A copy of the post-discharge plan will be provided to the resident and with consent the resident representative and copy will be filed in the medical record. This deficiency substantiates Complaint Number OH 221.

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.