STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVANA HEALTH CARE CENTER	**609 NORTH HARPHAM STREET HAVANA, IL 62644**

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** Based on record review and interview, the facility failed to obtain a physician's order, complete a discharge assessment/documentation and ensure documentation regarding medication and ongoing care was provided to the resident and caregiver at the time of discharge, for two of five residents (R1 and R2) reviewed for involuntary discharge in a sample of 10. Findings Include: The facility policy, titled Transfer and Discharge Policy and Procedure (no date) documents, It is the policy of Petersen Health Care no to transfer or discharge a resident unless: 1. The transfer or discharge is necessary to meet the residents welfare, and the residents welfare cannot be met in the facility; or 2. The transfer is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; or 3. The safety of the individuals in the facility is endangered; or 4. The health of individuals in the facility would be endangered; or 5. The resident has failed, after reasonable and appropriate notice to pay for a stay in the facility; or 6. The facility ceases to operate. In all cases except the last, documentation in the resident's clinical record shall be required. The residents attending physician must document in the resident's clinical record that the facility cannot provide for the resident's welfare, or that the resident no longer requires the facilities services. The policy later documents, under Involuntary Transfers or Discharges, A Physician's discharge order shall be obtained in the resident's record prior to discharge and Prior to transfer or discharge the Social Service Director shall counsel the resident and summarize the counseling session in the resident's record. The facility policy, titled Nursing Transfer/Discharge Assessment Policy (no date) documents, To ensure the resident is transferred in an appropriate condition an assessment will be conducted prior to departure, except in an emergent situation. Responsibility: Licensed nursing staff. Procedure: 1. Obtain orders to transfer/discharge the resident from the facility. 2. Conduct a head to toe assessment of the resident prior to discharge. Note the condition of the skin and the cleanliness of the resident. 3. Document assessment findings on the Nursing Transfer/Discharge Assessment Form. The facility policy, titled Discharge Planning (11/01/17), documents It is the policy of this facility to assist each individual resident to make decisions in advance of discharge about the rehabilitative, psychosocial and health care goals of the resident. Whether resident of facility initiated, its the intent of the facility to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution, provider, home care giver or resident themselves to ensure continuity of care and services is maintained by developing and implementing a discharge plan in advance of the actual resident discharge. The policy continues by documenting, 10. Upon discharges without anticipation of return, a discharge summary of care and services shall be completed using the IDT (interdisciplinary team) Discharge summary. 11. A copy of the Post Discharge Plan of Care and Medication list shall be provided to the resident/responsible party upon discharge. A copy of the IDT Discharge Summary may be provided upon request. 12. A copy of the Post discharge Plan of Care and Medication list may be made available to the continuing care provided to who the resident is discharged with the consent of the resident/responsible party. A copy of the IDT Discharge summary may also be made available upon request with the consent of the resident/responsible party. 13. Follow up interviews shall be conducted within 3 and 14 days after discharge and documented in the (Social Service Directors) notes. A Discharge Log documents R1 and R2 was discharged to home on 8/07/20. 1. A Plan of Care dated 12/18/19, for R1 documents Resident discharge is immanent sic. Resident desires to discharge to non-nursing home level of care. Family/Caregiver supportive of discharge. Estimate length of time before discharge. Discharge Destination. Resident specific information. Resident will participate in discharge planning to ensure compliance and consistency in need assessment and plan. Evaluate needs of resident/caregiver beginning on admission day and continuing evaluation throughout stay. Anticipate need for services and equipment including possibly respiratory equipment, hospital bed, wheel chair, walker, cane, home care services of CNA (Certified Nursing Assistant), nurse, social worker, financial services, spiritual/clergy services. That same Plan of Care later instruct staff to Facilitate nursing teaching of procedures, (medication) regime, etc. Specific tasks needed to learn. and Discuss discharge plan with physician and obtain orders as necessary for equipment and services. Provide written and oral direction for plan of care including (medication) regime to resident and caregiver. Social Service Notes, dated 4/17/20, document R1's was given a Notice of Involuntary Transfer and Discharge for non-payment, with a proposed discharge date was 5/17/20. R1 signed the Involuntary Transfer or Discharge Request for Hearing on 4/22/20. On 5/13/20, Social Service Notes by V3 (Social Service Director)document that R1 had not yet been discharged as they continue to work with (R1) on returning to the community. On 7/08/20, V3 documents that she is still assisting R1 to find housing and working with community service programs. The next note written by Social Services is on 8/08/20 and simply documents, (R1) discharged . The Physician's Order Sheet does have a order, written the day after R1 was discharged (8/08/20), stating may discharge (with) current (medications and follow up with physician next (week). The last nursing note documented in R1's medical record was documented on 7/20/20. There is no corresponding documentation in nursing notes, social service notes or assessments related to R1's discharge, or a discharge summary to detail where R1 was discharged to or care needs at the time of discharge. At the time of discharge, R1's Physicians' Orders dated 8/01/20, document she was to receive the following: Aspirin 81 mg (milligrams) at 8:00 am, Vanlafaxine ER 150 mg at 8:00 am, Oxybutinin 5 mg at 8:00 am and 5:00 pm, Atrovastatin 40 mg at 5:00 pm, Vitamin D 400 Units at 8:00 am, [MEDICATION NAME] 75 mg at 8:00 am and 5:00 pm, Calcium with Vitamin D 600 mg/200 units at 8:00 am, [MEDICATION NAME] 20 mg at 8:00 am and 5:00 pm, [MEDICATION NAME] 20 mg at 8:00 am, Losartan/HCTZ 100-12/5 mg at 8:00 am, [MEDICATION NAME] 300 mg at 8:00 am and 5:00 pm. R1's medical record contains no documented evidence of a post discharge summary or post discharge plan of care. 2. A Minimum Data Set assessment, dated 5/14/20, documents R2 as being cognitively intact, with the [DIAGNOSES REDACTED]. Social Service Notes, dated 4/17/20, document R2's was given a Notice of Involuntary Transfer and Discharge for non-payment, with a proposed discharge date was 5/17/20. R2's Social Service notes, from 4/21/20 through 8/04/20 contain extensive documentation by V3, attempting to find placement for R2 through different social service programs; however, the only documentation from Social Services on the date of R2's discharge (8/07/20), documents Phoned (Adult Protective Services and Counselor) left voicemail for them to call this writer back. There is no documentation after that and no documentation regarding R2 even discharging from the facility. The last nursing note in R2's medical record was dated 7/08/20, clarify an order for [REDACTED]. At the time of discharge, R2's Physician Orders dated 8/01/20, document the following: Diagnoses: [REDACTED]. Activity Level: Up with 1-2 assist, turn and reposition every two hours. Treatment orders: Keep pressure off right lateral foot and use protective covering, Change (indwelling) catheter monthly and catheter

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVANA HEALTH CARE CENTER	609 NORTH HARPHAM STREET HAVANA, IL 62644

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	(continued... from page 1) care every shift, Apply Lamisal cream twice daily to rash on abdomen. Diet: Liquid supplement 120 ml (milliliters) three times per day. medications: [REDACTED]. R2's medical record contains no documented evidence of a post discharge summary or post discharge plan of care. On 8/31/20 at 11:40 am, V3 (Social Service Director) stated she had been working on finding placement for R1 and R2 for months, but R1 had some unrealistic expectations. V3 stated around 10:30 am she received instruction from the corporate office that R1 and R2 had to leave immediately for lack of payment. V3 stated R2 would have qualified for continued skilled nursing services at the facility, but she was her own person and wanted to be with her Mother (R1) who had been her primary caregiver. V3 stated the only thing R1 and R2 were provided by the facility when they left around 1:00 pm was a wheelchair for R2. V3 stated, other than the wheelchair, no other supplies was sent with them or documented instructions. On 9/01/20 at 10:30 am, V4 (Licensed Practical Nurse) stated she was directed by the corporate office late morning of 8/07/20 that R1 and R2 had to immediately leave the facility. V4 was unable to get a physician's order for discharge or medication in time, so staff transferred R1 and R2 without medication, supplies or documentation of care instructions. V4 stated that is not the normal protocol for a resident's discharge and the resident is normally prepared. V4 stated she did get a physician's order to discharge and give R1 and R2 their medication the following day, on 8/08/20. V4 stated she delivered R1 and R2's medication to them on her way home around 3:00 pm. On 8/31/20 at 11:25 am, V4 stated the protocol when a resident is discharged to home is for the medication to go with them and written discharge instructions, unless their payor source won't allow the medication to leave the facility with them. V4 stated in that case, they would work with the pharmacy of choice and ensure the medications were called in and able to be picked up. On 8/31/20 at 12:00 pm, V5 (Business Office Manager) stated on the morning of 8/07/20, V5 received notification from the Corporate Office that R1 and R2 had to leave the facility that day. R1 decided she and R2 to go to the local hotel, as they had no place to immediately go to. V5 transported R1 and R2 to the hotel in the facility van, but the room would not be ready for several hours. V5 then contacted R1's Sister-in-Law and asked if they could stay with her temporarily, which she agreed. V5 was not given any documented instructions for R1 and R2's care, medication, or supplies for R2's indwelling catheter at the time she transported them. On 8/31/20 at 7:40 am, R1 (Mother) stated she and R2 (Daughter) were abruptly told on 8/07/20 that they had to leave the facility that day over not being able to pay. R1 stated she and R2 received a 30 day Involuntary Discharge Notice, but could not recall exactly when. R1 stated on 8/07/20, she and R2 were told by V3 (Social Service Director) that they had to leave right now, so R1 reserved a room at a local motel, but when they got there the room wouldn't be ready for several hours. R1 stated staff called R1's Sister-in-law to see if they could be dropped off at her house and she agreed. R1 stated she and R2 was rushed out of the building and the staff didn't give them any medications or instructions regarding medical needs. R1 stated in the afternoon on 8/08/20, someone from the facility dropped off she and R2's medication, but they had already missed some of their doses at that point. R1 stated staff left, but no instructions and nothing telling her what needed to be done for R2's indwelling catheter. R1 could not recall how long they went without catheter care supplies for R2, but stated she ended up having to arrange for the local hospital send supplies for R2's catheter care by the request of her physician.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident discharge was orderly and provide discharge instructions for medications/treatments for continuation of care prior to transfer/discharge for two of five residents (R1 and R2) reviewed for Involuntary Transfer/Discharge, in a sample of 10. Findings include: The facility policy, titled Transfer and Discharge Policy and Procedure (no date) documents, under Involuntary Transfers or Discharges, A Physician's discharge order shall be obtained in the resident's record prior to discharge and Prior to transfer or discharge the Social Service Director shall counsel the resident and summarize the counseling session in the resident's record. The facility policy, titled Discharge Planning (11/01/17), documents It is the policy of this facility to assist each individual resident to make decisions in advance of discharge about the rehabilitative, psychosocial and health care goals of the resident. Whether resident of facility initiated, its the intent of the facility to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution, provider, home care giver or resident themselves to ensure continuity of care and services is maintained by developing and implementing a discharge plan in advance of the actual resident discharge. The policy continues by documenting, 10. Upon discharges without anticipation of return, a discharge summary of care and services shall be completed using the IDT (interdisciplinary team) Discharge summary. 11. A copy of the Post Discharge Plan of Care and Medication list shall be provided to the resident/responsible party upon discharge. A Discharge Log documents R1 and R2 were discharged to home on 8/07/20. 1. A Plan of Care dated 12/18/19, for R1 documents Resident discharge is immanent sic. Resident desires to discharge to non-nursing home level of care. Family/Caregiver supportive of discharge. Estimate length of time before discharge. Discharge Destination. Resident specific information. Resident will participate in discharge planning to ensure compliance and consistency in need assessment and plan. Social Service Notes, dated 4/17/20, document R1's was given a Notice of Involuntary Transfer and Discharge for non-payment, with a proposed discharge date was 5/17/20. On 7/08/20, V3 (Social Service Director) documents in Social Service Notes, that she is still assisting R1 to find housing and working with community service programs. The next note written by Social Services is on 8/08/20, and simply documents, (R1) discharged . The physician's orders [REDACTED]. The last nursing note documented in R1's medical record was documented on 7/20/20. There is no corresponding documentation in nursing notes, social service notes or assessments related to R1's discharge, or a discharge summary to detail where R1 was discharged to or care needs at the time of discharge. 2. Social Service Notes, dated 4/17/20, document R2's was given a Notice of Involuntary Transfer and Discharge for non-payment, with a proposed discharge date was 5/17/20. R2's Social Service notes, from 4/21/20 through 8/04/20 contain extensive documentation by V3, attempting to find placement for R2 through different social service programs; however, the only documentation from Social Services on the date of R2's discharge (8/07/20), documents Phoned (Adult Protective Services and Counselor) left voicemail for them to call this writer back. There is no documentation after that and no documentation regarding R2 even discharging from the facility. The last nursing note in R2's medical record was dated 7/08/20, clarify an order for [REDACTED]. R1 (Mother) stated she and R2 (Daughter) were abruptly told on 8/07/20 that they had to leave the facility that day. R1 stated V3 (Social Service Director) told her that they had to leave right now. R1 stated she and R2 had no place to go, so she reserved a room at a local motel. R1 stated they were rushed out of the building and They told me nothing about medical needs for myself or (R1). They sent nothing to care for her (R2) catheter. We had no medicine sent with us, no paperwork, no nothing. R1 stated when the transport van arrived at the motel, they were told that the room wouldn't be ready for several hours. R1 stated staff called R1's Sister-in-law to see if they could be dropped off at her house and she agreed, but she wasn't ready for us. On 8/31/20 at 11:40 am, V3 (Social Service Director) stated she had been working on finding placement for R1 and R2 for months, but R1 had some unrealistic expectations. V3 stated around 10:30 am on 8/07/20 she received instruction from the corporate office that R1 and R2 had to leave immediately for lack of payment. V3 stated the only thing R1 and R2 were provided by the facility when they left around 1:00 pm was a wheelchair for R2. V3 stated, other than the wheelchair, no other supplies were sent with them or documented instructions and described the situation as chaotic, with R2 crying over leaving the facility. On 9/01/20 at 10:30 am, V4 (Licensed Practical Nurse) stated she was directed by the corporate office late morning of 8/07/20 that R1 and R2 had to immediately leave the facility. V4 was unable to get a physician's orders [REDACTED]. V4 stated that is not the normal protocol for a resident's discharge and the resident is normally prepared. On 8/31/20 at 11:25 am, V4 stated the protocol when a resident is discharged to home is for the medication to go with them and written discharge instructions, unless their payor source won't allow the medication to leave the facility with them. V4 stated in that case, they would work with the pharmacy of choice and ensure the medications were called in and able to be picked up. V4 stated this was the first time she has ever been given such a directive to get residents out of the facility. V4 stated R2 was upset and crying when they were leaving and had hugged all the staff. On 8/31/20 at 12:00 pm, V5 (Business Office Manager) stated on the morning of 8/07/20, V5 received notification from the Corporate Office that R1 and R2 had to leave the facility that day, as soon as possible. V5 stated R1 decided she and R2 would have to go to the local hotel, as they had no place to immediately go to. V5 transported R1 and R2 to the hotel in the facility van, but the room would not be ready for several hours. V5 then contacted R1's Sister-in-Law and asked if they could stay with her temporarily. V5 stated she made sure the house she dropped them off at could accommodate R2's wheelchair. V5 was not given any documented instructions for R1 and R2's care, medication, or supplies for R2's indwelling catheter at the time she transported them.