STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND HEALTHCARE & REHAB CENTER	**340 E SOUTH STREET RICHMOND, KS 66080**

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** The facility reported a census of 52 residents with five residents sampled for admission, transfer, and discharge. Based on interview and record review the facility failed to provide bed-hold notifications to 4 of the 5 residents and/or their representatives at the time of transfer to the hospital including Resident (R) 5, R8, R 9, and R 10,. Findings included: - Review of the facility's Action Summary Report, dated 01/21/2020 through 07/20/2020, documentation included five residents R4, R5, R8, R 9, and R10, who transferred back to the hospital during their Medicare A stay in the facility. Review of the medical records for these residents revealed the facility failed to provide the following residents and/or their representatives with a bed-hold notification at the time of the hospital transfers: 1. On 01/25/2020, the facility transferred R8 to the hospital and failed to provide a bed-hold notice. 2. On 03/03/2020, the facility transferred R9 to the hospital and failed to provide a bed-hold notice. 3. On 05/08/2020 and 05/28/2020 the facility transferred R10 to the hospital and failed to provide a bed-hold notice. 4. On 06/23/2020 and 06/30/2020 the facility transferred R5 to the hospital and failed to provide a bed-hold notice. On 7/21/2020 at 1: 22 PM, Licensed Nurse (LN) G stated bed hold notices were available at the nurses' station. When hospital transfers occur, the nurse is normally handling the acute change in the resident's condition and it is a difficult time for them to issue the form. The admissions director usually follows-up on the bed-hold notices. On 07/22/2020 at 11:30 AM, Administrative Nurse D confirmed these residents did not receive a bed hold notification. She stated that Medicare A residents were not given a bed-hold notice. Administrative Nurse D provided facility policy which she confirmed directed bed-hold notification should be provided to all residents transferred/discharged with return anticipated regardless of payment source. Additionally, she reported the facility Quality Assurance Committee reviewed the policy for Bed-holds on 01/07/2020. The facility AR102 Bed-Holds, policy, dated 01/07/2020, documentation included when a resident is transferred out of the service location to the hospital, the designee will provide the resident/representative with the written bed-hold notice regardless of pay source. The facility failed to provide bed-hold notifications to these 4 residents and/or their representatives at the time of transfer to the hospital as required.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 52 residents with seven residents sampled for discharge summary. Based on interview and record review, the facility failed to develop a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status at the time of discharge, and a post discharge plan of care for two of the 7 residents reviewed, Resident (R) 1 and R11. Findings included: - Review of the medical records for the following residents revealed the residents had discharged from the facility with return not anticipated and lacked a discharge summary within 30 days of discharge, as required: 1. On 01/31/2020, the facility discharged Resident (R) 11 to another facility with return not anticipated, the resident's clinical record lacked a discharge summary. 2. On 06/05/2020, the facility discharged R1 to the hospital with return not anticipated, due to an emergency discharge. The resident's clinical record lacked a discharge summary. On 7/21/2020 at 1: 22 PM, Licensed Nurse (LN) G confirmed she did not complete the discharge summary for R 1 and she was the charge nurse on duty on 06/5/2020. She stated the nurse who discharges the resident was responsible for completion of the discharge summary. LN G stated there was a lot going on at the time and several staff involved in the discharge and she did not get it done. On 7/22/2020 at 11:30 AM, Administrative Nurse D confirmed R 1 discharged on [DATE], and R 11 discharged [DATE], both residents lacked a discharge summary. She stated she expected the nurse who discharged the resident to complete the discharge summary to include a discharge summary addressing the recapitulation of stay, a final summary of the resident's status at the time of discharge, and a post discharge plan of care. The facility Bed-Hold and Discharge &Transfer, policy, dated 01/07/2020, failed to address the completion of discharge summaries. The facility failed to complete the required discharge summary that included a recapitulation of the residents stay, a final summary of the resident's status at the time of discharge, and a post discharge plan of care within 30 days of discharge for these residents.

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.