STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 9/26/19 through 9/30/19. One complaint was investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 174 certified bed facility was 124 at the time of the survey. The survey sample consisted of 4 closed record reviews (Residents #1 through #4).	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws requires it. This Plan of Correction serves as the facility's allegation of compliance.	
F 557 SS=G	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide a dignified discharge, resulting in psychological harm for one resident (Resident #1) in a survey sample of four residents. The findings included: For Resident #1, facility staff coerced Resident #1 into signing an AMA form. The facility evicted him	F 557	F 557 Respect, Dignity/Right to have Personal Property Resident #1 no longer resides in the facility Current residents/responsible parties will be interviewed to identify any respect and dignity issues concerns. Concerns voiced including those of dignity and respect will be reported to Executive Director (ED)/ Director of Nursing (DON) for resolution. Senior Operations Director (SOD) will re-educate ED/DON on residents rights of dignity and respect. ED/designee will re-educate facility staff on resident rights of dignity and respect during interaction, provision of care and services. Staff will report concerns to ED/DON.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 10/30/2019

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 557	Continued From page 1 against his will. The facility staff humiliated him by laughing at him in the lobby of the facility. The facility staff transported him along with his belongings to the front lawn of his sister's apartment. Resident #1 was left alone in an unsafe condition without access to a bathroom, food, water, medication, or access to shade, where he suffered humiliation, anxiety, shame and public embarrassment. Resident #1 was a 64 year old, was admitted to the facility on 8/8/19. Resident #1's diagnoses included Bilateral Legs Amputation, End Stage Renal Disease, Dependence of Renal Dialysis, Heart Failure, Major Depression, and Generalized Muscle Weakness. The Minimum Data Set, which was a 30-Day Assessment with an Assessment Reference Date of 9/5/19 was reviewed. Resident #1 had a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. In addition, he was coded as not having any mood or behavioral issues. Resident #1 was dependent on a wheelchair for mobility. On 9/26/19 a review was conducted of facility documentation, revealing a complaint that was submitted by Resident #1's sister on 9/24/19. An excerpt read: "On 9/19/19 he went to dialysis and when he came back to the facility, all of his things were packed up in their van and he was told that he was not welcome back into the facility. The facility then took him to her apartment in their van. She came home and her brother was sitting in the yard ...her apartment is not equipped for someone that is a double amputee ...she was not notified that he was being discharged to her apartment ...he sat in her yard for two hours after	F 557	Department manager will conduct interviews with residents during rounds to identify respect and dignity concerns and concerns will address by ED/DON. ED/designee will ensure a resolution is met with satisfaction of the resident/responsible party. The quality monitoring results will be bought to QAPI monthly for 3 months or until resolved. October 25, 2019	

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F 557	Continued From page 2 having dialysis earlier that day." On 9/26/19 at 12:30 P.M. an interview was conducted with the facility van driver (Employee F) in the conference room. The driver was asked to describe the circumstances under which she transported Resident #1 to his sister's address. She stated, "I was told by the Administrator to drop him off at his sisters' home. He had signed himself out. His stuff was already packed up. He had 3 boxes, an artificial leg, and a cane. He was in a wheelchair. I loaded him up. I took him 6 minutes away. I put boxes down and I left him on the grass in the front. I dropped him off at 1:00 P.M. It was a quiet ride. I have taken people home before. Normally there is someone there." She stated that she knew that his sister was not at home. On 9/27/19 at approximately 10:30 A.M., a telephone interview was conducted with Resident #1, and his sister. Resident #1 stated that on 9/18/19, facility staff gave him an AMA (Against Medical Advice) form to sign while he was lying on a gurney. He was awakened by Emergency Medical Services (EMS), and was being transported out of the facility. He stated that the facility staff did not explain what the form was for, nor the consequences of signing out of the facility AMA. He stated that the EMS personnel asked him why he had called 911. He told them that he was taking a nap, and had not called them. He had no reason to want to go to the hospital. After a few minutes, the facility staff admitted to the EMS that the facility had called 911. Resident #1 stated that the hospital did not treat him, nor perform any tests. (this was confirmed during a review of his hospital records). He	F 557		

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F 557	Continued From page 3 stated the hospital informed him that the facility did not want him to return there because he had signed himself out AMA. After several hours, the facility allowed him to return. He stated that upon his return on the evening of 9/18/19, all of his belongings were missing from his room. The staff denied knowing where his belongings were. Resident #1 stated that on the morning of 9/19/19, he went to his regularly scheduled dialysis appointment. Upon his return, the facility refused to allow him to go past the lobby, or to eat lunch. His belongings had been packed up in boxes and put on the facility van. He stated that while he was in the lobby, "A white woman with long hair who was one of the social workers looked at me and laughed at me [Employee J-Social Services Director]. I felt humiliated. The van driver asked me for an address to drop me off at. The driver dropped me off in the yard in front of my sister's apartment with my boxes. I was anxious, embarrassed and felt shame sitting out there alone in public." Resident #1 said that the driver knew that his sister was not at home. He stated that the driver left him outside in the sun without any food, water, medication, or access to a bathroom. He stated that he was there alone for at least two hours until his sister came home.	F 557		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600	F 600 Free from Abuse and Neglect Resident #1 was discharged and no longer resides in the facility.	

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F 600	Continued From page 4 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff neglected to provide safe discharge services, for one resident (Resident #1) in a survey sample of 4 residents. The findings included: 1. For Resident #1, the facility neglected to implemented procedures to ensure a safe discharge. Resident #1 was a 64 year old, was admitted to the facility on 8/8/19. Resident #1's diagnoses included Bilateral Legs Amputation, End Stage Renal Disease, Dependence of Renal Dialysis, Heart Failure, Major Depression, and Generalized Muscle Weakness. The Minimum Data Set, which was a 30-Day Assessment with an Assessment Reference Date of 9/5/19 was reviewed. Resident #1 had a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. In addition, he was coded as not having any mood or behavioral issues. Resident #1 was dependent on a	F 600	Residents being discharged have the potential to be affected by the alleged deficient practice. Residents with planned discharges will be reviewed to ensure a safe discharge by verifying the discharge location/placement, mobility/accessibility needs can be met, medications or prescriptions provided, and other home care needs such as appointments home health, and arrangement for personal equipment. Residents being discharged against medical advice, staff will notify the physician, family/responsible party (if known), and as appropriate, Adult Protective Services, and document contacts. Resident will be educated by nursing staff member and social services member on the healthcare consequences, and safety concerns.	

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F 600	Continued From page 5 wheelchair for mobility. On 9/26/19 a review was conducted of Resident #1's clinical record. According to Resident #1's current physician orders, he was on the following medications: Coumadin 15 MG by mouth daily Tylenol 325 MG 2 tablets by mouth every 6 hours for pain Albuterol 2 ML inhalation every 4 hours as needed for wheezing Atorvastatin 40 MG 1 tablet by mouth daily Symbicort 160 MCG 2 puffs twice daily Calcitriol 0.25 MCG 1 capsule by mouth daily Epoetin Alfa injectable (given at dialysis) Gabapentin 300 MG 1 capsule by mouth at bedtime Metoprolol 25 MG 0.5 tablet by mouth every 12 hours Mirtazapine 30 MG 1 tablet by mouth at bedtime Senna 8.6 MG 2 tablets by mouth at bedtime for constipation Trazodone 50 MG 0.5 tablet by mouth at bedtime Resident #1's Care Plan dated 8/16/19 was reviewed. An excerpt read, "has an ADL (Activities of Daily Living) self-care performance deficit r/t [related to] bilateral Above knee Amputations, Limited Mobility, shunt, dialysis, Hypertension, Chronic Obstructive Pulmonary Disease. 15 minute safety checks, cow bell use." On 9/26/19 a review was conducted of facility documentation, revealing a complaint that was submitted by Resident #1's sister on 9/24/19. An excerpt read: "On 9/19/19 he went to dialysis and when he came back to the facility, all of his things were packed up in their van and he was told that he was not welcome back into the facility. The	F 600	RDCS will re-educate the Executive Director, Director of Nursing, and Social Services on discharge policies including Discharge planning, and leaving Against Medical Advice. Social worker, nursing staff will be re-educated on documenting discussion and making the appropriate notifications when resident leaves against medical advice. Residents with planned discharges will be reviewed in morning meeting when discharge date is confirmed and social worker will send notification to departments to coordinate discharge when date is confirmed to verify discharge plan is appropriate for resident needs. Facility will not longer provide transport to Against Medical Advice (AMA) residents. Quality monitoring results will be bought to QAPI for review and recommendations for 3 months or until resolved. October 25, 2019	

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F 600	Continued From page 6 facility then took him to her apartment in their van. She came home and her brother was sitting in the yard ...her apartment is not equipped for someone that is a double amputee ...she was not notified that he was being discharged to her apartment ...he sat in her yard for two hours after having dialysis earlier that day." On 9/26/19 at 12:30 P.M. an interview was conducted with the facility van driver (Employee F) in the conference room. The driver was asked to describe the circumstances under which she transported Resident #1 to his sister's address. She stated, "I was told by the Administrator to drop him off at his sisters' home. He had signed himself out. His stuff was already packed up. He had 3 boxes, an artificial leg, and a cane. He was in a wheelchair. I loaded him up. I took him 6 minutes away. I put boxes down and I left him on the grass in the front. I dropped him off at 1:00 P.M. It was a quiet ride. I have taken people home before. Normally there is someone there." She stated that she knew that his sister was not at home. On 9/27/19 at approximately 10:30 A.M., a telephone interview was conducted with Resident #1, and his sister. Resident #1 stated that on 9/18/19, facility staff gave him an AMA (Against Medical Advice) form to sign while he was lying on a gurney. He was awakened by Emergency Medical Services (EMS), and was being transported out of the facility. He stated that the facility staff did not explain what the form was for, nor the consequences of signing out of the facility AMA. He stated that the EMS personnel asked him why he had called 911. He told them that he was taking a nap, and had not called them. He had no reason to want to go to the hospital. After	F 600		

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F 600	Continued From page 7 a few minutes, the staff admitted that the facility had called 911. Resident #1 stated that the hospital did not treat him, nor perform any tests. (this was confirmed during a review of his hospital records). The hospital informed him that the facility did not want him to return there because he had signed himself out AMA. After several hours, the facility allowed him to return. Upon his return on the evening of 9/18/19, all of his belongings were missing from his room. The staff denied knowing where his belongings were. On the morning of 9/19/19, he went to his regularly scheduled dialysis appointment. Upon his return, the facility refused to allow him to go past the lobby, or to eat lunch. His belongings had been packed up in boxes and put on the facility van. He stated that while he was in the lobby, "A white woman with long hair who was one of the social workers looked at me and laughed at me . I felt humiliated. The van driver asked me for an address to drop me off at. The driver dropped me off in the yard in front of my sister's apartment with my boxes. I was embarrassed and ashamed sitting out there in public." Resident #1 said that the driver knew that his sister was not at home. He stated that the driver left him outside in the sun without any food, water, medication, or access to a bathroom. He stated that he was there alone for at least two hours until his sister came home. Resident #1's sister stated that his friend went to the facility to visit him on 9/19/19 and was informed that he no longer lived there. His friend	F 600		

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F 600	Continued From page 8	F 600		

called her to find out where he was. Resident #1's sister stated that she had not been informed that he would be taken to her apartment. She stated that her apartment was not accessible or "appropriate for a double amputee." She stated that upon her arrival home, she had no immediate way to get him into her home. There was no wheelchair ramp. She stated that she "had to get someone to go another location to obtain two wooden boards to get him up over the stairs."

In addition, the facility did not obtain his permission to be sent to the hospital. On 9/18/19 at 4:21 P.M., an excerpt from a nursing progress note read, "Oxygen sats [saturation] 96%-99%. No behavior problems noted. No education provided. Noted resident poking tissue in nose with a small amount of blood on tissue. NP (Nurse Practitioner) aware. Orders to send resident to the hospital for evaluation."

On 9/26/19 at approximately 4:05 P.M., an interview was conducted with the facility Administrator (Employee A) in the conference room. When asked why Resident #1 had been sent to the hospital on 9/18/19, the Administrator stated that Resident #1 wanted to go to the hospital due to a "little bit of blood" that came out of his nose earlier that morning. The Administrator further stated that on 9/18/19 the hospital called the facility and stated that the resident was ready for discharge, but were told that he left the facility AMA. She stated that the hospital was upset with the facility and stated, "Y'all always say your residents left AMA." The Administrator stated that she then agreed to allow Resident #1 to return that night to the facility. The Administrator was asked why Resident #1

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F 600	Continued From page 9 did not voluntarily leave the facility on 9/18/19, when the AMA was dated. She stated that he wanted to go to the hospital. The Administrator further stated that Resident#1 had been issued a 30 Day Discharge Notice on 8/28/19 because a cigarette lighter was found in his room. She stated that the facility officially became smoke-free on September 1, 2019. The Administrator stated that she did not have an obligation to wait 30 days. She stated, "We don't have to wait 30 days. Every now and then we would take them and make sure they are in a safe place as a courtesy. Because of his BIMS of 15 we can discharge him. He was cognitively aware of his decision to go AMA. We discharged him and delivered him to the address he specified." When asked to show documentation that Resident #1 was transported to a safe, appropriate location, the Administrator reviewed his progress notes, which had been provided to the surveyor. She was unable to find any documentation of such. On 9/26/19 a review was conducted of Resident #1's hospital discharge form dated 9/18/19 at 2:12 P.M. An excerpt read, "Stated Complaint: Sent by [facility] for drug addiction ...64 year old male patient with ESRD (End Stage Renal Disease) on dialysis with bilateral below the knee amputation was sent by facility for drug screen but does not make urine. Patient denies any medical complaints. Denies any substance use. Will send back to facility. Patient sent for drug screen. Patient unable to make urine due to chronic kidney disease on dialysis. Emergency Room does not routinely do serum drug testing for screening purposes. Discharged at 3:21 P.M. The hospital made multiple calls to the facility to	F 600		

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F 600	Continued From page 10 obtain permission the send him back there. At 6:45 P.M., approximately three and one-half hours after the hospital discharged Resident #1, the facility finally agreed to allow him to return. On 9/26/19 a review was conducted of facility documentation, revealing a policy on Leaving Against Medical Advice dated 8/24/17. An excerpt read: "Procedure: Attempt to resolve concerns contributing to desire to leave AMA. The resident will be informed of the risks involved, the benefits of staying in the center, and the alternatives to both. Nursing will document this discussion in the nursing section of the medical record. The social services designee will document any discussions held with the resident in the social service section of the medical record." Resident #1's clinical record did not contain any documentation that a nurse informed of the risks involved, or the benefits of staying in the center, or the alternatives, or discussions with the Social Worker. On 9/30/19 at 3:30 P.M. an interview was conducted with the Social Worker (Employee I) in the conference room with 2 surveyors present (Surveyor A, Surveyor B). The Social Worker was asked to describe the circumstances under which Resident #1 signed an AMA. She stated, I was told he wants to go AMA. I gave him the paper. I read what it says." She stated that she was in his room after the EMS had arrived and that he was on his bed. She stated that she told him that the facility could not take care of him if he signed out AMA, and that he said that his girlfriend could take care of him. The Social Worker was asked why the AMA form had not been properly completed, by including the physicians name. She stated that she just put the form down on her	F 600		

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F 600	Continued From page 11 desk because she didn't believe he wanted to leave that facility, and she said to the Administrator, "we'll see where this goes". The Social worker was asked why she did not try to find other appropriate placement for Resident #1. She stated, she had called one facility, but "He did not want to give up his stuff." The Social Worker was unable to show documentation of any further attempts to locate an appropriate, safe living arrangement. The Social Worker had never spoken with Resident #1's sister regarding placement. On 9/30/19 a review was conducted of facility documentation, revealing a policy on Abuse, Neglect, Exploitation & Misappropriation dated 11/28/17. An excerpt read, "No employee at any time may commit an act of physical, psychological, or emotional abuse, neglect, mistreatment ...Mental abuse if the use of verbal or nonverbal conduct which causes or has to potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. Mental and Verbal Abuse include, but are not limited to: Mocking, insulting, ridiculing ..."	F 600		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced	F 624	F 624 Resident #1 no longer resides in the facility. Social Services and Nursing will explain to residents desiring to leave facility AMA of the consequences of leaving against medical advice such as not having medications, appointments, needed referrals and equipment, etc.; document specifics of education and resident response in the medical record. RDCS will re-educate the ED/designee on the process of AMA. Documentation will be reviewed during the morning meeting for accurate documentation of orientation and education to the resident. Quality monitoring results will be bought to QAPI for review and recommendations for 3 months or until resolved. October 25, 2019	

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by:
Based on staff interview, resident interview, and facility documentation review, the facility staff failed to orient for a discharge in a manner and form the resident could understand, failed to prepare, and failed to document in the clinical record one resident (Resident #1) in a survey sample of 4 residents.

The findings included:

Resident #1 was a 64 year old, was admitted to the facility on 8/8/19, and evicted against his will on 9/19/19. Resident #1's diagnoses included Bilateral Legs Amputation, End Stage Renal Disease, Dependence of Renal Dialysis, Heart Failure, Major Depression, and Generalized Muscle Weakness.

The Minimum Data Set, which was a 30-Day Assessment with an Assessment Reference Date of 9/5/19 was reviewed. Resident #1 had a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. In addition, he was coded as not having any mood or behavioral issues. Resident #1 was dependent on a wheelchair for mobility.

On 9/26/19 a review was conducted of facility documentation, revealing a complaint that was submitted by Resident #1's sister on 9/24/19. An excerpt read: "On 9/19/19 he went to dialysis and when he came back to the facility, all of his things were packed up in their van and he was told that he was not welcome back into the facility. The facility then took him to her apartment in their van. She came home and her brother was sitting in the yard ...her apartment is not equipped for someone that is a double amputee ...she was not

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F 624	Continued From page 13 notified that he was being discharged to her apartment ...he sat in her yard for two hours after having dialysis earlier that day." On 9/26/19 at 12:30 P.M. an interview was conducted with the facility van driver (Employee F) in the conference room. The driver was asked to describe the circumstances under which she transported Resident #1 to his sister's address. She stated, "I was told by the Administrator to drop him off at his sisters' home. He had signed himself out. His stuff was already packed up. He had 3 boxes, an artificial leg, and a cane. He was in a wheelchair. I loaded him up. I took him 6 minutes away. I put boxes down and I left him on the grass in the front. I dropped him off at 1:00 P.M. It was a quiet ride. I have taken people home before. Normally there is someone there." She stated that she knew that his sister was not at home. On 9/27/19 at approximately 10:30 A.M., a telephone interview was conducted with Resident #1, and his sister. Resident #1 stated that on 9/18/19, facility staff gave him an AMA (Against Medical Advice) form to sign while he was lying on a gurney. He was awakened by Emergency Medical Services [EMS], and was being transported out of the facility. He stated that the facility staff did not explain what the form was for, nor the consequences of signing out of the facility AMA. He stated that the EMS personnel asked him why he had called 911. He told them that he was taking a nap, and had not called them. He had no reason to want to go to the hospital. After a few minutes, the staff admitted to the EMS that the facility had called 911. Resident #1 stated that the hospital did not treat	F 624		

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him, nor perform any tests. (this was confirmed during a review of his hospital records). The hospital informed him that the facility did not want him to return there because he had signed himself out AMA. After several hours, the facility allowed him to return. Upon his return on the evening of 9/18/19, all of his belongings were missing from his room. The staff denied knowing where his belongings were.

Resident #1 stated, on the morning of 9/19/19, he went to his regularly scheduled dialysis appointment. Upon his return, the facility refused to allow him to go past the lobby, or to eat lunch. His belongings had been packed up in boxes and put on the facility van. He stated that while he was in the lobby, "A white woman with long hair who was one of the social workers looked at me and laughed at me [Employee J-Social Services Director]. I felt humiliated. The van driver "asked me for an address to drop me off at." The driver dropped me off in the yard in front of my sister's apartment with my boxes. "I was embarrassed and ashamed sitting out there in public."

Resident #1 said that the driver knew that his sister was not at home. He stated that the driver left him outside in the sun without any food, water, medication, or access to a bathroom. He stated that he was there alone for at least two hours until his sister came home.

Resident #1's sister stated that his friend went to the facility to visit him on 9/19/19 and was informed that he no longer lived there. His friend called her to find out where he was. Resident #1's sister stated that she had not been informed that he would be taken to her apartment. She stated that her apartment was not accessible or

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F 624	Continued From page 15	F 624		

"appropriate for a double amputee." She stated that upon her arrival home, she had no immediate way to get him into her home. There was no wheelchair ramp. She stated that she "had to get someone to go another location to obtain two wooden boards to get him up over the stairs."

In addition, the facility did not obtain his permission to be sent to the hospital. On 9/18/19 at 4:21 P.M., an excerpt from a nursing progress note read, "Oxygen sats [saturation] 96%-99%. No behavior problems noted. No education provided. Noted resident poking tissue in nose with a small amount of blood on tissue. NP (Nurse Practitioner) aware. Orders to send resident to the hospital for evaluation."

On 9/26/19 at approximately 4:05 P.M., an interview was conducted with the facility Administrator (Employee A) in the conference room. When asked why Resident #1 had been sent to the hospital on 9/18/19, the Administrator stated that Resident #1 wanted to go to the hospital due to a "little bit of blood" that came out of his nose earlier that morning. The Administrator further stated that on 9/18/19 the hospital called the facility and stated that the resident was ready for discharge, but were told that he left the facility AMA. She stated that the hospital was upset with the facility and stated, "Y'all always say your residents left AMA." The Administrator stated that she then agreed to allow Resident #1 to return that night to the facility.

The Administrator was asked why Resident #1 did not voluntarily leave the facility on 9/18/19, when the AMA was dated. She stated that he wanted to go to the hospital.

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F 624	Continued From page 16 The Administrator further stated that Resident#1 was given a 30 Day Discharge Notice on 8/28/19 because a cigarette lighter was found in his room. She stated that the facility officially became smoke-free on September 1, 2019. The Administrator stated that she did not have an obligation to wait 30 days. She stated, "We don't have to wait 30 days. Every now and then we would take them and make sure they are in a safe place as a courtesy. Because of his BIMS of 15 we can discharge him. He was cognitively aware of his decision to go AMA. We discharged him and delivered him to the address he specified." When asked to show documentation that Resident #1 was transported to a safe, appropriate location, the Administrator reviewed his progress notes, which had been provided to the surveyor. She was unable to find any documentation of such. On 9/26/19 a review was conducted of Resident #1's hospital discharge form dated 9/18/19 at 2:12 P.M. An excerpt read, "Stated Complaint: Sent by [facility] for drug addiction ...64 year old male patient with ESRD (End Stage Renal Disease) on dialysis with bilateral below the knee amputation was sent by facility for drug screen but does not make urine. Patient denies any medical complaints. Denies any substance use. Will send back to facility. Patient sent for drug screen. Patient unable to make urine due to chronic kidney disease on dialysis. Emergency Room does not routinely do serum drug testing for screening purposes. Discharged at 3:21 P.M." The form showed the hospital made multiple calls to the facility to obtain permission the send him back there. At 6:45 P.M., approximately three and one-half hours after the	F 624		

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F 624	Continued From page 17 hospital discharged Resident #1, the facility finally agreed to allow him to return. On 9/26/19 a review was conducted of facility documentation, revealing a policy on Leaving Against Medical Advice dated 8/24/17. An excerpt read: "Procedure: Attempt to resolve concerns contributing to desire to leave AMA. The resident will be informed of the risks involved, the benefits of staying in the center, and the alternatives to both. Nursing will document this discussion in the nursing section of the medical record. The social services designee will document any discussions held with the resident in the social service section of the medical record." Resident #1's clinical record did not contain any documentation that a nurse informed of the risks involved, or the benefits of staying in the center, or the alternatives, or discussions with the Social Worker. Resident #1's Care Plan dated 8/16/19 was reviewed. An excerpt read, "has an ADL (Activities of Daily Living) self-care performance deficit r/t [related to] bilateral Above knee Amputations, Limited Mobility, shunt, dialysis, Hypertension, Chronic Obstructive Pulmonary Disease. 15 minute safety checks, cow bell use." On 9/30/19 at 3:30 P.M. an interview was conducted with the Social Worker (Employee I) in the conference room with 2 surveyors present (Surveyor A, Surveyor B). The Social Worker was asked to describe the circumstances under which Resident #1 signed an AMA. She stated, I was told he wants to go AMA. I gave him the paper. I read what it says." She stated that she was in his room after the EMS had arrived and that he was on his bed. She stated that she told him that the	F 624		

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F 624	Continued From page 18 facility could not take care of him if he signed out AMA, and that he said that his girlfriend could take care of him. The Social Worker was asked why the AMA form had not been properly completed, by including the physicians name. She stated that she just put the form down on her desk because she didn't believe he wanted to leave that facility, and she said to the Administrator, "we'll see where this goes". The Social worker was asked why she did not try to find other appropriate placement for Resident #1. She stated, she had called one facility, but "He did not want to give up his stuff." The Social Worker was unable to show documentation of any further attempts to locate an appropriate, safe living arrangement. The Social Worker had never spoken with Resident #1's sister regarding placement. On 9/30/19 a review was conducted of facility documentation, revealing a policy on Discharge Planning, dated 11/30/14. There was no revision date. An excerpt read, "At the time of discharge, a discharge summary and home-going instructions are provided ... including current diagnosis, rehabilitation potential, summary of prior treatment, physician's orders for immediate care, pertinent social information, community referrals (e.g. home health, mental health, adult day care, etc.). Residents discharged to home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs.. Within twenty-four to forty-eight hours after the discharge to home ...a follow-up phone call or if necessary home visit will be made to ascertain that community services/referrals are indeed being provided according to the discharge plan ...Documentation of the after discharge contact will be made on the	F 624		

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F 624	Continued From page 19 social services note."	F 624		