STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard (complaint) survey was conducted 01/22/2020 through 01/23/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 180 certified bed facility was 151 at the time of the survey. The survey sample consisted of 2 closed record reviews (Residents #1 and #2).	F 000	1) Resident 1 discharged NHRC on 06/18/2019 and was admitted to Sentara Norfolk General. 2) Moving forward, effective immediately, long term care patients with active Medicaid that have been discharged from the facility to a hospital setting will be allowed readmission to NHRC. The facility will also not allow refusals of care to be criteria for decisions on readmission.	2-14-2020
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to	F 626	3) Facility Admissions department will be reeducated on readmission regulations no later than 02/14/2020 4) Facility administrator will monitor the admissions department to ensure that department stays compliant with admission regulations. The administrator will complete a random weekly audit of discharged residents seeking readmission who are medicare/medicaid eligible to ensure that those residents are readmitted to the facility from the hospital. The administrative audits will be presented to the QA committee for review and recommendation until the issue is determined to be resolved by the QA committee. 5) Issues noted will be presented to QA committee for review and reconciliation during quarterly sessions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 2-7-2020

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 626	Continued From page 1 discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, facility documentation review and in the course of a complaint investigation, the facility staff failed to permit 1 resident (Resident #1) out of a sample of 2 residents to return to the nursing facility after a discharge to the hospital, who was Medicare/Medicaid eligible and required those services provided by the facility. The findings include: Resident #1 was admitted to the nursing facility on 9/22/18 with diagnoses that included end stage renal disease (ESRD) on dialysis, high blood pressure, atherosclerotic heart disease and generalized muscle weakness. The resident was discharged to the hospital on 12/18/18 and readmitted to the nursing facility on 12/26/18 with a diagnosis of congestive heart failure (CHF) and pulmonary artery hypertension (PAH). Resident #1 was discharged a second time to hospital on 6/18/19 and did not return. The discharge Minimum Data Set (MDS) dated 12/18/18 coded the resident as "return	F 626		

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F 626	Continued From page 2	F 626		

anticipated." The discharge MDS dated 6/18/19 coded the resident as "not eligible to return." The admission MDS dated 9/29/18 and readmission MDS dated 12/26/18 did not code the resident with physical, verbal or other behavioral symptoms toward self or others. The MDS prior to Resident #1's last discharge (6/18/19) from the facility was a quarterly dated 4/9/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was fully intact with the cognitive skills for daily decision making.

The care plan dated 10/8/18 and 5/30/19 did not code the resident to be a danger to self or others. Care plans dated 10/4/18 to 6/12/19 identified the resident refused assistance with activities of daily living (ADL) and medications which was essentially a continuous practice from original admission throughout the resident's stay. The resident was scheduled for dialysis on Mondays, Wednesdays and Fridays. The resident was also care planned for antipsychotic medication, Seroquel 25 milligrams (mg), 1 tablet, ordered on 9/22/18 at bedtime for sleep. The Psychiatrist evaluated the resident on 10/29/18 and the Seroquel was reduced to 12.5 mg at bedtime for mild cognitive impairment. Melatonin 5 mg was also ordered at bedtime. The Psychiatrist assessed the resident again on 11/5/18 with treatment goals to alleviate insomnia. The Melatonin was increased from 5 mg to 8 mg as a result of this visit and to continue Seroquel 12.5 mg at bedtime. Both visits with the Psychiatrist revealed the resident was calm and cooperative with no psychotic episodes, no delusional ideation and mood was within normal limits, and no danger to self or others. There were no further

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F 626	Continued From page 3 visit with the psychiatrist in 2019. On 1/23/20 at 12:00 p.m., an interview was conducted with the MDS Coordinator. She stated she followed the Resident Assessment Instrument (RAI) manual to coded whether a resident's return after discharge would or would not be be anticipated. She stated usually a resident is coded as "Return Anticipated" if they have been hospitalized. She stated she would have to investigate why Resident #1 was coded "Return Not Anticipated" upon his discharge on 6/18/19. The MDS Coordinator returned on 1/23/19 at approximately 1:15 p.m. and stated, "I guess the Team decided he was not going to return and the business office informed be that he had been issued a 30 day discharge notice, so he could not return." The Discharge Planning Admission Assessment dated 10/2/18 conducted by the social worker indicated that discharge plan was short term, the resident was alert and oriented and would need ADL support in the community. It was documented the resident's mood and behavior was appropriate for his care and encouragement required to assist him to socialize with others and that the resident was able to participate in basic decisions. It was noted that the resident's son was the financial and medical Power of Attorney (POA). The Discharge Planning Reassessments dated 10/30/18 and 12/3/18 indicated the resident was expected to remain in the facility, continued to participate in skilled services and Medicaid approval pending. The Discharge Planning Reassessment dated	F 626		

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F 626	Continued From page 4 4/12/19 indicated the resident was still able to make independent decisions, and the discharge plan was Long Term Care (LTC) under Medicaid benefits. The Discharge Planning Reassessment dated 6/16/19 indicated the resident was encouraged to participate in out of room activities and socialize with other residents to increase his social skills. The discharge plan was LTC under Medicaid benefits. An interview with the Administrator and the Director of Nursing (DON) was conducted on 1/22/20 at 11:00 a.m. The Administrator stated a 30 day discharge notice was issued to a resident if it was the resident's choice, in cases of violence, non-compliance with safety rules related to self and others, not able to provide the care and services, transition out of therapy and no payer source (Medicaid will renew). The Administrator said if the hospital admits a resident and they had been issued a 30 day discharge notice and they are inside the 30 day, the facility is obligated to take them back, but if at 30 days there was no obligation to take the resident back. On 1/23/20 at 12:30 p.m., a phone interview was conducted with the hospital case manager. She stated on 6/20/19, two days into the resident's hospital admission, she spoke with the nursing facility's admission liaison that informed her they would not be taking the resident back if and when he was cleared for readmission due to an outstanding balance. She stated she was told, the resident would not either make the nursing facility the representative payee nor would he pay his coinsurance balance. She said she was told the	F 626		

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F 626	Continued From page 5	F 626		

resident was admitted pending his Medicaid application and became approved for Medicaid on 3/12/19. She stated she spoke to the Administrator on 6/27/19, which was the actual day the resident was medically cleared to be discharged from the hospital to have the facility to reconsider his re-admission. She said the Administrator told her Resident #1 had a high balance owed to the facility and that he was non-compliant with care and dialysis. She stated she forwarded her concern to the State Ombudsman's office who agreed with her that the resident should have been allowed to return to the nursing facility.

On 1/23/20 at 1:10 p.m., an interview was conducted with the Social Worker (SW). She stated the resident was admitted on Medicare and also received social security. She stated although the resident's son had medical and financial power of attorney, the resident was alert and fully capable to have a "say so" over how he managed his social security funds. She stated the resident was issued a 30 day discharge notice on 2/12/19, but once he was approved for Medicaid on 3/12/19, the decision was made that he would become a permanent LTC resident, thus she did not pursue any discharge plans to the community. There was no evidence that any action had been taken by the SW to find placement for the resident and he was not discharged because on 3/12/19 he was approved for Medicaid.

The Business Office Manager (BOM) joined the above interview along with documentation and verified the resident was issued a 30 day discharge notice on 2/12/19 due to the fact that he had accrued a substantial outstanding balance. The BOM stated regardless of the

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F 626	Continued From page 6 Medicaid approval the discharge notice was still in place and pending because there was still an outstanding balance from December 2019 to the current month. She stated although the resident was approved for Medicaid in March 2019, when he was discharged to the hospital on 6/18/19, he still owed a balance to the facility, thus he was not allowed to return. On 1/23/20 at 1:37 p.m., an interview was conducted with the Administrator and the Corporate Nurse. The Administrator stated that the State Ombudsman came in to inquire as to why Resident #1 was not allowed to return to the facility and he informed him that based on the balance owed and non-compliance with taking medications and missed dialysis treatments he did not have to take the resident back. When asked if the Ombudsman was in agreement with that rational, he stated, "No, he felt based on the resident's specific situation, he should have been allowed to return." The Administrator stated that based on the continued 30 discharge notice issued February 12, 2019, although family was unwilling to accept the resident, the SW was actively pursuing many placement opportunities in the community and was unsuccessful. The SW was called back in the room to further clarify what opportunities the Administrator was referring to. The SW stated, "I was wrong when I told you (referring to this surveyor) the team agreed to keep him once he became Medicaid. I should have sought placement opportunities, but I did not." On 1/23/20 at 2:45 p.m., the Administrator and Corporate Nurse stated that upon review of the Federal regulation for situations that permitted return of the facility, Resident #1 should have	F 626		

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F 626	Continued From page 7 been allowed to return due the fact that he was Medicaid eligible when sent out to the Emergency Department and admitted to the hospital and required services covered by Medicare/Medicaid at the time of his discharge. It was also discussed that refusal of ADL and medications, which was a practice of the resident from his original admission, to include three dialysis sessions, was not criteria to exclude the resident from re-admission to the nursing facility. The Corporate Nurse stated that some revisions would be made to their current discharge and transfer policy and procedures, along with inservices.	F 626		