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	495280	A. BUILDING _____ B. WING _____	C 11/10/2020

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E000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 11/10/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 44 certified bed facility was 27 at the time of the onsite survey.	E000		
F000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey and Abbreviated (complaint) survey, was conducted 11/10/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.	F000	Westminster at Lake Ridge is filing this Plan of Correction (POC) for the purpose of regulatory compliance. This Center is submitting this POC to comply with applicable laws and not as an admission or statement of agreement with alleged deficiencies herein. To remain compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following POC. The following plan of corrections constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action will be accomplished for all residents who could be affected by the alleged deficient practice as follows: F660: Discharge Planning Process CFR(s): 483.21 (c) (1) (i)-(ix) 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

Administrator 12/04/20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 1 of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received	F 660	Corrective action will be accomplished for all residents who could be affected by the alleged deficient practice as follows: a)The discharge care plan (CP) for all residents was reviewed and or updated on 11/25/2020 through 12/07/2020. b) The IDT team reviewed discharge plans at the morning meeting 5-6 daily until all residents in house were completed c)The Social Services Director or designee shall be responsible for checking and or updating discharge plans. d) The discharge plan summary shall be completed by the LCSW as discharge rights et forth set forth at 483.15(b) and indicated in Westminster's Lake Ridge policy. e) The ADON and or designee shall in-service IDT team and RN staff on the Westminster Lake Ridge discharge planning process policy.	12/07/2020 12/31/2020 12/31/2020 12/31/2020

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F 660	Continued From page 2 from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure post-discharge needs and services were in place for 1 resident (Resident #1) in a sample size of three residents. For Resident #1, the facility staff failed to ensure	F 660	The health center (HC will) identify other residents having the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected. All residents with discharge plans within the past 30 days will have their care plan reviewed and updated if necessary with appropriate interventions. All existing measures will be reviewed and confirmed in place. Systemic changes if any will be ,made to ensure that the alleged deficient practice does not recur Licensed staff will be re-educated on updating the discharge care plan during the IDT review and whenever necessary IDT team will review all discharges at scheduled morning meeting to evaluate that appropriate interventions have been added to the care plan. 4. The corrective action will be monitored to ensure the alleged deficient practice will not recur. All residents pending discharge will have their discharge care plan audited by LCSW or designee for updated interventions weekly for 4 weeks ,and 2 per week thereafter for 2 months. Results of audits will be reviewed by the quality assurance team to determine ongoing audit schedule. 5. a) All corrective action shall be completed on or before 1/7/2021	12/31/2020 12/31/2020 1/7/2021

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F 660	Continued From page 3 the availability of a caregiver for assistance/supervision with standing/ambulation in her apartment on the day of discharge, 09/30/2020. The findings included: Resident #1 was admitted to the facility on 09/01/2020 and discharged on 09/30/2020. Diagnoses for Resident #1 included but are were not limited to diabetes, chronic obstructive pulmonary disease, and dementia. Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 09/08/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15", indicative of intact cognition. Functional status for transfers was coded as requiring extensive assistance from staff with 2+ persons' physical assistance for support. "Walk in Room" was coded as limited assistance and one person physical assistance for support. On 11/10/2020, the closed clinical record was reviewed. A social worker note written by Employee D, the social worker, dated 09/29/2020 at 2:40 P.M. documented, "Discharge note: Home health care PT/OT [physical therapy/occupational therapy] and nursing has been arranged for [Resident #1] with [agency name]. She will return to her apartment tomorrow September 30th. Therapy is conducting a home safety assessment this afternoon. Writer spoke briefly with her daughter [name] and reviewed the above plans with her. The home care company name and number will be provided to [Resident #1]."	F 660		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 4 The occupational discharge summary dated 09/29/2020 at 5:22 P.M. under the header, "D/C Recs" [discharge recommendations]", it was documented, "Discharge Recommendations: rollator, HHOT [home health occupational therapy], HEP [home education program], AM/PM caregiver." A nurse's discharge note dated 09/30/2020 at 2:33 P.M. documented, "Patient was admitted from [hospital name] to [facility name] for rehab, with diagnosis of diarrhea, dizziness. Patient participated well with therapy and nursing with no setback. Patient received current medication list, left over of [sic] medications, copies of discharged summary from [facility], copies of discharged summary from [hospital name], care plan. Advanced directives sent with resident and will continue to home with HHA [home health aide], PT [physical therapy], OT [occupational therapy], Aide, DME [durable medical equipment]. Education provided to patient on disease process, administration of medications, and adverse reactions to medications, patient understood teaching, nurse ask if there is any further questions or clarifications needed, Patient stated no questions, stated that she understood's [sic] what was explained. On 09/30/20 at 14:45hrs [2:45 P.M.] patient was discharged from [facility], departed facility safely accompanied by CNA [certified nurse assistant]." The physical therapy discharge summary dated 09/30/2020 at 2:18 P.M. under the header, "STG #2.0 [short-term goal #2] - met on 09/17/2020" documented, "Patient will perform sit to stand transfers and simulated car transfers with SBA [stand-by assist] demonstrating safe techniques." Under the sub-header, "Baseline (09/04/2020)", it	F 660		

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F 660	Continued From page 5 was documented, "Min A/CGA [minimum assist/contact guard assist." Under the header "Status/Prior Living/Discharge" and sub-header D/C [discharge] Location" it was documented, "Patient discharged to resident at ILF [independent living facility]. Under the sub-header, "Assistance/Support to be Provided", it was documented, "AM assistance/caregiver available." Under the header, "Discharge Recommendations and Status" and sub-header, "D/C Recs [discharge recommendations]", it was documented, "D/C to self/family care. Recommended home health or out-patient PT [physical therapy] for continued strengthening in order to achieve PLOF [prior level of function]." The physician's discharge summary dated 09/30/2020 under the header "Musculoskeletal" selected the option "unsteady gait " On 11/12/2020 at approximately 12:55 P.M., an interview with Employee D, the social worker, was conducted. When asked how long she had been working at the facility, Employee D stated she had been working at the facility since September 14th (2020). Employee D verified she is the only social worker working at the skilled facility. When asked about her general process for discharge planning, Employee D stated that she ensures they (the Residents) have the services they need. Employee D stated that she'll make arrangements for personal care assistants if that's needed. When asked if she follows up to ensure services are in place, Employee D stated that "it is my normal practice to follow up." When asked within what period of time would do a follow-up, Employee D stated that it depends on the situation. When asked about follow up if a resident needed home health services, Employee	F 660		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 6 D stated she would make sure that home health services had come by the following week but "usually the day after discharge." When asked about Resident #1, Employee D stated that she "vaguely" remembers Resident #1. Employee D stated Resident #1 was in the skilled facility and returned to her apartment in independent living. Employee D then referred to her discharge note dated 09/29/2020 and stated that Resident #1 had home health services. When asked why Resident #1 needed home health services, Employee D stated she did not know Resident #1's diagnosis but that she was discharged with home health, physical therapy, and occupational therapy services. When Employee D was asked if she did a follow-up to ensure all equipment and services were in place, Employee D stated "I did not follow up." When asked why a follow-up wasn't done, Employee D stated that she thought "others" were going to do the follow-up. On 11/10/2020 at approximately 1:30 P.M., an interview with Employee E, the Director of Rehab, was conducted. When asked about Resident #1's functional ability, Employee E referred to the clinical record and stated that at baseline, Resident #1 was able to stand and walk 10 feet with contact guard assist. When asked if Resident #1's functional ability improved prior to discharge, Employee E stated yes. Employee E then stated that Resident #1 required stand-by assist to stand and supervision/contact guard assist to ambulate 200 feet with a front-wheeled walker. When asked about therapy recommendations, Employee E stated that therapy recommended home health, physical therapy, occupational therapy, and an A.M./P.M. caregiver.	F 660		

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F 660	Continued From page 7 When asked who coordinates the services needed for home, Employee E stated "the social worker." When asked how therapy recommendations are communicated, Employee E stated that they verbally tell the resident and the interdisciplinary team. In reference to Resident #1, Employee E stated that she notified the interdisciplinary team of discharge recommendations for Resident #1. When asked who was on the team, Employee E stated the social worker, the MDS Coordinator, and a nursing representative. On 11/10/2020 at approximately 1:55 P.M., an interview with Employee G was conducted. Employee G stated that her role is Director of Clinical Services, the nurse that oversees private pay cases for [outside company name]. Employee G stated that she spoke with Resident #1 and Resident #1's son prior to Resident #1's day of discharge (09/30/2020). Employee G stated that Resident #1 and Resident #1's son indicated they would be needing home care services after discharge from the skilled facility. Employee G also stated that the first home visit occurred on 10/01/2020 after Resident #1 called her. When Employee G was asked if she had any communication with the facility social worker pertaining to the day of discharge and what services were needed, Employee G stated no. On 11/10/2020, the facility staff provided a copy of a document entitled, "Post Discharge Plan of Care." Under the Section entitled, "Therapy Instructions" completed by Employee E, the Director of Rehab, dated 09/30/2020 at 11:16 A.M., the following sub-headers and selections included but not limited to: "Transfers:	F 660		

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F 660	Continued From page 8 Supervision; Toileting: Supervision; Other Precautions: Balance concerns, should have supervision." Under the Section entitled, "Services Needed" completed by Employee D, the social worker, dated 09/30/2020 at 11:56 A.M., the following sub-headers and selections were documented: "Home Health Agency [agency name]; Private Duty Care Agency [agency name]; Follow-up Appointments: See your Primary Physician within 7-10 days from discharge & take this form with you." Physical therapy, occupational therapy, medical equipment, and physician appointments were not selected/completed. The facility staff provided a copy of their policy entitled, "Discharge Summary and Plan." Section 1 documented, "When the facility anticipates a resident's discharge to a private residence ....a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment." Under Section 5 entitled, "The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will include:" subpart (b) documented, "Arrangements that have been made for follow-up care and services." On 11/10/2020 at approximately 5:30 P.M., the administrator was notified of findings.	F 660		