

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

FORM APPROVED  
OMB NO. 0938-0381

RECEIVED

AUG 18 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185200	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  C 07/23/2012
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NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT BLVD. P.O. BOX 725 WHITESBURG, KY 41858
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F 000	INITIAL COMMENTS	F 000	Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.	
F 159 SS=C	<p style="text-align: center;">—Amended—</p> <p>An abbreviated standard survey (KY18754) was conducted on 07/23/12. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p><b>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds</p>	F 159	<p><b>F159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Letcher Manor follows "generally accepted accounting principles" and employs bookkeeping with strict internal control procedures. Written authorization is obtained to handle resident funds in addition to providing individual recordkeeping, maintenance of receipts and provision of quarterly statements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charla E. Disher TITLE: Administrator (X6) DATE: 8/17/12

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 159	<p>Continued From page 1 of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide access to personal funds for five of five unsampled residents interviewed (Residents A, B, C, D, and E). Interviews with five unsampled alert and oriented residents revealed they had been unable to access their personal funds in a timely manner for the past two to three months (May, June, and July 2012).</p> <p>The findings include: An interview with the Facility Administrator on 07/23/12, at 6:30 PM, revealed the facility had a policy entitled Facility Management of Monthly Benefits (dated 01/09/03); however, the policy did not include specific timeframes for the distribution of resident personal funds when requested by the resident.</p>	F 159	<p>Resident fund accounts are interest bearing. Letcher Manor strives to ensure personal funds are readily available and within reasonable access to residents.</p> <p>Several methods are utilized by residents to deposit funds into the escrow account, and those funds that are direct deposited must follow banking rules. Local banks are not open on weekends or holidays. Deposits that are made are not available to withdraw until the following day. Deposits were within reasonable timeframes during the three months as indicated. The normal protocol for the facility is to transfer funds to escrow the first day they are available at the bank. For May, the deposit was made on the 3<sup>rd</sup> (Thursday), available on the 4<sup>th</sup> and transferred to escrow on the 7<sup>th</sup> (Monday), a three day time frame due to the weekend and limitations on bank availability. The deposit timeframe in June experienced two (2) weekends between bank transfers, was deposited on the 1<sup>st</sup> (Friday), but was not available to withdraw until the 4<sup>th</sup> (Monday), creating the appearance of an 8 to 10 day delay, but in actuality the timeframe was 5 working days. For July, deposits were made the 3<sup>rd</sup> (Tuesday) and transferred to escrow on the 5<sup>th</sup> (Thursday), as July 4<sup>th</sup> was a holiday. It is the policy of this facility to comply with regulatory requirements. This is evidenced as follows:</p> <ol style="list-style-type: none"> <li>1. <u>Resident A</u> had funds available at all times in his/her escrow account throughout the three month review. This resident has SSI which deposits by the 1<sup>st</sup> of each month directly into the escrow account and was available without delay. <u>Resident B</u> had funds available in his/her escrow account on the dates in question,</li> </ol>		

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F 159	<p>Continued From page 2</p> <p>An interview with five unsampled alert and oriented residents (Residents A, B, C, D, and E) revealed their monies were deposited into their accounts on either the first or the third of each month. However, according to resident interviews, for the past two to three months, their funds were not available to them until late in the month that it was deposited. The residents interviewed were unsure of exact timeframes.</p> <p>Interview with Office Staff Person #1 on 07/23/12, at 3:20 PM, revealed she had assisted the Administrator with the management of resident accounts since March 2012, when the previous person responsible had ended their employment with the facility. Further interview with Office Staff Person #1 revealed most of the residents in the facility had their money directly deposited into their own bank accounts. However, according to Office Staff Person #1, there were several residents that had their monies deposited, by the first or the third of the month, into an account maintained for them by the facility. According to Office Staff Person #1, "Once the residents' funds have been direct deposited into the bank, the facility's Corporate Office breaks the residents' money up to where it should go, so the residents' funds are not actually available until after that takes place." Continued interview with Office Staff Person #1 revealed in the month of June 2012, even though the residents' money was deposited by the third day of the month, the residents' money had not arrived to the facility to be available for resident access until 06/11/12, (eight to ten days after it had been deposited). Office Staff Person #1 stated June had been the only month the facility had a delay in receiving the</p>	F 159	<p>stating their response was \$40 is not enough for personal spending. This is not within the facility control.</p> <p><u>Resident C</u> had funds available to withdraw at all times in his/her escrow account throughout the entire three months.</p> <p><u>Resident D</u> had funds available at all times in his/her escrow account throughout the three month period.</p> <p><u>Resident E</u> had funds available to withdraw in his/her escrow account on the dates reviewed. Family handles finances for this resident and had not brought in funds at this time for deposit. Per regulatory guidelines, the facility is not responsible for knowing about assets that is not deposited with it.</p> <p>Above residents had not previously indicated during resident council meetings or to management staff a perceived issue with resident escrow availability. Each resident was interviewed on July 24, 2012, and did not indicate any further concerns or dissatisfaction with management of resident funds. All residents listed above indicated they had received all monies. All staff involved in the management of resident funds was re-educated on resident fund regulations on July 23, 2012.</p> <p>2. To identify other residents who may have had the potential to be affected, a review was performed on all resident escrow accounts on July 23, 2012. No other residents were found to have been affected. No other resident had a zero balance in this account. Other residents are not expected to be affected due to the implementation of #3 and #4 below.</p>	

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F 159	Continued From page 3 residents' monies.  An interview with the Facility Administrator on 07/23/12, at 8:30 PM, confirmed the facility managed the personal accounts for several residents in the facility and stated the residents' money is deposited into the residents' bank accounts timely. However, according to the Administrator, the facility's Corporate Office transfers the residents' money into three separate accounts, managed by the Corporate Office, prior to the facility and or the residents having access to their personal funds.	F 159	3. To ensure the practice will not recur, educational in-services were held by the Administrator on July 23, 2012 with the Corporate VP of Administration and all front office staff regarding regulatory requirements and facility policies related to resident funds; and the same shall be reviewed with this same staff if and/or when a concern is identified. Additionally, to ensure the practice will not recur, a backup system at the corporate level was implemented in the event the staff responsible for this transfer is not available. A second person, the VP of Finance, at the corporate level was trained by the VP of Administration to perform this same function to ensure transfers are done and timeframes are met.	
F 204 SS-D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG  A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.  This REQUIREMENT is not met as evidenced by: Based on interviews, closed record review, and a review of facility policy, it was determined the facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility for one of three sampled residents (Resident #1). Resident #1 was discharged from the facility on 06/05/12, at the resident's request. Interview and record review revealed facility staff failed to notify the resident's family of the resident's discharge from the facility and as a result, no one was present at the resident's home to provide care for the resident once the resident arrived home.  The findings include:	F 204	4. To ensure solutions are sustained, the facility escrow accounts shall be monitored by the Financial Coordinator on a monthly basis. Monitoring shall include review of reasonable timeframes to ensure funds are available and distributed according to regulatory and policy guidelines and to ensure that the bank transfer is met within a few days, no more than three bank working days. The Financial Coordinator shall notify the Administrator and Vice President of Administration for immediate correction should it be found the timeframe is not met. In addition, a quality assurance form shall be revised to include discussion on a quarterly basis with the resident council regarding the escrow funds and any issues thereof. The QA Coordinator shall also implement quality assurance measures to review compliance with regulations for	

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F 204	Continued From page 4  A review of the facility policy entitled Transfer and Discharge Requirements (dated 01/09/03) revealed the policy did not include guidance to staff related to a resident's request for discharge to ensure the discharge was safe and orderly.  A review of the medical record for Resident #1 revealed the facility admitted the resident on 03/30/12, with diagnoses of Cerebral Vascular Accident resulting in right-sided paralysis, Cervical Spine Fracture with Stenosis, Diabetes, and a Diabetic Foot Ulcer. A review of the Admission Minimum Data Set (MDS) assessment dated 04/11/12, revealed facility staff had assessed Resident #1 to be alert and oriented, and able to make him/herself understood and to understand others. Continued review of the MDS assessment revealed Resident #1 required extensive assistance with transfers, ambulation, dressing, hygiene, and eating, and was frequently incontinent of bowel and bladder.  Continued review of Resident #1's medical record revealed on 06/05/12, approximately two months after admission, the resident requested to be discharged from the facility. Documentation revealed at the time of the resident's request Resident #1 continued to require extensive assistance from staff with transfers, ambulation, dressing, hygiene, and eating, and was frequently incontinent of bowel and bladder. Further review of the record revealed facility staff contacted the resident's physician and obtained orders for the resident's discharge home. However, it could not be determined by documentation provided that Resident #1's family had been notified of the resident's pending discharge.	F 204	escrow/trust accounts on a quarterly basis, and shall evaluate annually for on-going review. Evaluation reports will be distributed by the QA Coordinator to the Administrator for review and appropriate action to be taken as necessary. If solutions are not maintained, corrective action shall be implemented, including, but not limited to education, increased sampling or increase in periodic monitoring. 5. F159 July 24, 2012  F204 483.12 (a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHARGE Letcher Manor transfer and discharge policies include the following: "Discharging a Resident Against Medical Advice" policy, "Discharge Plan" policy, "Transfer or Discharge Orientation" policy, "Transfer and/or Discharge Notice" policy, and "Transfer or Discharge: Preparing a Resident" policy. Through these policies the facility provides guidance to staff related to a resident's discharge and provides compliance for sufficient preparation and orientation for residents, as well as to ensure safe and orderly transfer or discharge from the facility. The policy named "Transfer or Discharge Orientation" requires a post discharge plan to be developed and reviewed with the resident and/or his/her family at least twenty-four (24) hours before the transfer/discharge from the facility. Therapy notes reflect compliance with this policy as the discharge plan was reviewed with both the resident and family on June 1, 2012. Education on assistive needs, safety issues, and home health information was provided to both the resident and the family.	07/24/12

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F 204	<p>Continued From page 5</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 07/23/12, at 1:35 PM, revealed she had been assigned to provide care for Resident #1 on the day of the resident's discharge. LPN #1 stated the resident had requested to be discharged and acknowledged she had not called the resident's family to notify them of the resident's discharge because the resident was his/her own responsible party. LPN #1 further stated even though the resident required extensive assistance with activities of daily living, she had not called the resident's family because the physician had said it was "ok" to discharge the resident.</p> <p>An interview was conducted on 07/23/12, at 2:10 PM, with the ambulance staff that transported Resident #1 home on the day of discharge. The ambulance staff stated no one was at Resident #1's home when they arrived and the ambulance staff did not feel it would be safe to leave the resident at home alone. The ambulance staff stated a neighbor agreed to provide care to the resident until the resident's family member arrived home.</p> <p>An interview with the Director of Nursing (DON) on 07/23/12, at 5:00 PM, revealed nurses should notify the resident's responsible party and/or family member at the time of discharge. The DON stated Resident #1 was his/her own responsible party, had requested to go home, and therefore the resident was discharged home and the resident's family member was not notified.</p>	F 204	<p>On June 1<sup>st</sup>, four (4) days prior to the transfer/discharge, therapy staff along with the resident and family, made a "trial home visit" to ensure a safe and orderly transfer/discharge. The resident demonstrated the ability to perform vehicle transfers with minimal assist, was able to propel a wheelchair throughout the home, and could perform multi surface transfers including wheelchair to bed and wheelchair to toilet. The home was measured for any needed modifications or assistive devices prior to the resident's return, to be in the safest environment possible.</p> <p>There is a significant difference between the MDS definition of "extensive" assist and therapy terms and definitions. According to the MDS dated 6/5/2012 the resident was continent of bowel and bladder. According to therapy notes during the last week of treatment, the resident demonstrated the ability to perform transfers with contact guard to minimal assistance and was ambulating greater than 250 feet with a rolling walker with only contact guard to stand by assistance. The resident was also performing lower body dressing/bathing with minimal assistance.</p> <p>Resident #1 was alert and oriented with a BIMS score of fifteen (15) throughout the entire admission, being capable and having the right to make the decision to discharge home without further treatment. The resident informed staff that he/she had experienced family discord on 6/4/12, stating the family was moving out of the house and the spouse was planning a divorce. The resident stated he/she had intentions to go home. Staff encouraged the resident to stay at the facility to further improve status; but, the resident insisted upon immediate discharge the following day. (Continued through page 10)</p>		

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Resident informed nurse aides working on the day of discharge that the spouse was aware of the discharge, and insisted the nurse call for transportation. The nurse notified the M.D., who provided discharge orders. The resident did not leave the facility against medical advice. The nurse contacted the ambulance to provide for safe transfer. The ambulance later notified the facility they could not get into the home. The facility requested they encourage the resident to return to the facility. The resident refused to return to the facility. The ambulance driver stated they could not force the resident to return to the facility, and informed the facility the resident's neighbor who had been assisting the family opened the house and agreed to stay with him/her until the family returned (from an out of town funeral). The family was not available for notification, as they had left town and failed to provide contact information or phone numbers to the facility. The family called back to the facility later and informed the staff that they were with the resident.

The "Admission Agreement", and also the "Discharge Plan" policy reflects the responsibility of the resident and/or representative to provide the facility with a minimum of seven (7) days notice of intended discharge to assure adequate discharge planning. Although a transfer/discharge plan had been initiated, the resident was non-compliant and elected to discharge prior to the anticipated date.

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The resident was non-compliant with providing notice.

This is evidenced as follows:

1. Resident #1 was alert and oriented, and being fully informed, exercised resident rights to end treatment and elected to suddenly discharge from the facility on June 5<sup>th</sup>. The resident and family were informed and were actively involved in discharge planning prior to this decision. Both were actively involved as to where he/she would be going. Staff had performed a home assessment and "trial visit" four (4) days prior to this sudden discharge. Counseling and education was provided to both the resident and family. A referral was made to Home Health to provide continued assistance with medical and treatment needs, and who visited the resident the following day. The spouse did not leave a forwarding contact/phone number to be notified. The nurse provided for a safe transfer with licensed ambulance personnel who remained with the resident until released to a friend. The resident was ambulatory with a rolling walker, was continent and able to transfer. Resident #1 was not in an unsafe situation at any given time during the transfer/ discharge. The facility complied with policy and provided to both the resident and family sufficient preparation and orientation related to the anticipated discharge.

Given the situation, the facility performed all aspects *within their control*, to ensure a safe and orderly transfer and preparation for the discharge.

2. Nursing Unit Coordinators reviewed all resident discharge plans on July 26, 2012. No other residents were identified to be deficient, in regards to the facility providing sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
3. To ensure the incident will not recur, an educational in-service was held, by the Director of Nursing and QA Staff Coordinator on August 3, 2012 with all nursing and social service staff to review all transfer/discharge policies (as noted above) and regarding facility protocol for sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Nursing staff included licensed and registered nurses. All new hires shall be oriented to the transfer/discharge policies upon new hire orientation; and these same policies shall be reviewed with staff, by the Director of Nursing, or her designee, if a concern is identified.  
To ensure this issue does not recur, the discharge form was changed by the Director of Nursing to add a question that will prompt all Charge Nurses overseeing a transfer/discharge to note/name the family member/responsible party that was contacted prior to transfer/discharge.

**COMPLETION DATE**

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4. To ensure solutions are sustained in regards to compliance with policies (as mentioned above), the Director of Nursing shall implement quality assurance measures, to review quarterly, and ensure the adherence to facility protocol for transfers/discharges. The QA Coordinator shall oversee compliance on a quarterly basis by review of ten percent (10%) of discharged residents medical records; and, shall report to the Director of Nursing any findings that are not within protocol. This measure shall be evaluated annually for on-going review. If solutions are not maintained, corrective action shall be implemented by the Director of Nursing and the policy shall be reviewed with affected staff if a concern is identified.

5. F 204 August 3, 2012

08/03/12

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