STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Terre Haute	3500 Maple Ave Terre Haute, IN 47804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38847 Based on observation, interview, and record review, the facility failed to issue a 30-day notice of discharge prior to the planned date of a facility-initiated discharge for 1 of 3 residents reviewed for discharges (Resident B). Findings include: During an interview, on 3/14/25 at 9:30 a.m., Qualified Medication Aide (QMA) 5 indicated she was working the unit Resident B resided on. He was discharging from the facility today, but she was not sure what time. QMA 5 indicated she was not sure where the resident planned to discharge, but the Social Services Director (SSD) should know. During an observation, on 3/14/25 at 9:33 a.m., Resident B was lying in bed with 3.5 liters (L) of oxygen via nasal cannula, and a catheter drainage bag was hanging on the side of the bed. At the same time, the resident indicated they have something planned but was unable to say what when asked if he planned to discharge from the facility that day. The resident did not know the year or who the president was. The resident's facial hair was untrimmed, and there was food on his chin. The resident indicated he did not care where he lived, and thought they might send him back to a motel. The resident denied requesting to discharge to a motel. He was not sure if he had Medicaid to pay for him to stay longer at the facility. The resident reported being unsure if he had a catheter and reached towards his groin area to check when asked. The resident was unable to verbalize how to care for his catheter, how much oxygen he required, how to turn the oxygen on and off, or how to apply the nasal cannula. During an interview, on 3/14/25 at 9:40 a.m., Resident B's family member indicated the facility notified her they planned to discharge Resident B to a motel because that was where he requested to go. The family member indicated the resident was not safe to discharge to a motel because he was unable to take care of himself. She was not issued a 30-day notice of discharge, and she did not think the resident was provided a notice either. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/25 at 9:46 a.m., the SSD indicated Resident B's discharge had been postponed because no home health care company would accept him as a patient if he resided in a motel. The SSD indicated she was not aware or involved with residents who might have payor issues, based on a lack of a secondary payor, until it came time for them to discharge. She was not sure what plans were discussed related to potential payor issues when the resident's Medicare Advantage plan cut his skilled stay, prior to her first conversation with the resident's family. She first discussed Resident B's potential discharge with his family member on 3/6/25. She was not sure if a 30 day notice of discharge should have been issued. The family member requested a referral be sent to another skilled nursing facility (SNF) because the family thought it was just a Medicare issue. The other SNF declined to admit the resident. The SSD did not indicate she attempted to provide education to the resident or family that the resident's Medicare Advantage plan would not pay for another SNF after he was cut from their facility's skilled stay. The SSD did not indicate she discussed other options with the resident or family, such as paying privately, planning a realistically safe discharge, or Medicaid. The SSD indicated discharge planning should have started on day one of the resident's admission to the facility, and she was the discharge coordinator, but she was unable to provide documentation the resident's payor issues or discharge had been discussed with the resident or family prior to 3/6/25. During an interview, on 3/14/25 at 9:52 a.m., Certified Nurse Aide (CNA) 6 indicated she was working the unit Resident B resided on. Resident B was sometimes alert and oriented but had some confusion. The resident needed one staff member to assist him with getting dressed, and two staff members with a Hoyer (mechanical lift) to get out of bed. The resident was not able to stand well. He sometimes got out of bed but not everyday. The resident would not have been able to get up, get dressed, and take care of himself if he lived alone in a motel. CNA 6 indicated the resident was scheduled to be discharged from the facility today, and she provided a paper schedule which indicated the resident was discharged to a motel, including the motel's name, address, and phone number. CNA 6 was not aware Resident B's discharge was postponed. During an interview, on 3/14/25 at 9:54 a.m., CNA 7 indicated she was familiar with Resident B and was working the unit he resided on. The resident needed the assistance of two staff members to get out of bed and recently they had started to use the Hoyer lift to get him up. The resident was incontinent of bowels. CNA 7 indicated Resident B would have been unable to take care of himself if he lived on his own. The resident had not ever completed his own catheter or oxygen care. The resident was pretty confused and was unable to understand things, such as why his knee hurt even though he recently had knee surgery. The resident usually wore a hospital gown. Resident B was scheduled to discharge from the facility today, and she was not aware of the discharge being postponed. Resident B's record was reviewed on 3/14/25 at 11:10 a.m. Census information indicated the resident was admitted to the facility on [DATE] with a Medicare Advantage plan payor, and there was no secondary, or back-up, payor. The resident's payor type changed to private pay on 3/14/25. Diagnoses on the resident's profile included, but were not limited to, sepsis (life-threatening condition when the body overreacts to an infection), unspecified osteomyelitis (bone infection), unspecified protein-calorie malnutrition, generalized muscle weakness, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD) (group of lung diseases causing breathing difficulties). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Conference Observation, dated 1/27/25, indicated the resident and the SSD attended the meeting, and the resident planned on staying in the facility long-term. The document did not indicate the SSD discussed with the resident options regarding what would happen when his Medicare Advantage plan cut the resident from the skilled stay since he planned to remain in the facility. There was no documentation of a plan for a secondary payor source once the Medicare Advantage plan stopped paying. An admission Minimum Data Set (MDS) assessment, dated 1/28/25, indicated the resident was cognitively intact. He required substantial/maximal staff assistance with toileting, showering/bathing, lower body dressing, putting on and taking off footwear, bed to chair transfers, toilet transfers, and tub and shower transfers. The resident required partial/moderate assistance with upper body dressing, personal hygiene, and rolling left and right. The resident had an indwelling catheter and was always incontinent of his bowels. The resident was at risk for pressure ulcers but had no pressure ulcers. The resident participated in the assessment process. The overall goal for discharge established during the assessment process was for the resident to stay in the facility long-term, and this information came from the resident's family. The assessment also indicated active discharge planning was in process for the resident to return to the community. A Progress Note, dated 2/3/25, indicated the resident's sister called the corporate compliance line with concerns of call light response timeliness and skilled services. The resident's sister came to the facility, and they met with the resident. The resident had some cognitive impairment and lapsed between showing understanding and answering questions appropriately to drifting off into nonsensical conversations. The resident was concerned that the facility allowed smoking, but he was required to be up in the wheelchair and propel himself to smoke. The resident previously lived in an infested motel. A care plan, initiated on 2/4/25, indicated the resident planned to discharge to the community. Interventions indicated arrange for medical equipment upon discharge, assist the resident with transportation as needed, discuss the discharge planning process with the resident and family, observe and report to the physician any changes in mood, behavior, cognition, and level of functioning caused by situational stressor and anticipated discharge, observe for psychosocial changes, provide the resident and/or representative with education as needed, provide services according to care plans in an effort to enhance optimum well-being and prevent hospitalization s, and secure any required state or insurance approval for transfer. The resident's record lacked documentation medical equipment was arranged in preparation of discharge or education was provided as indicated in the care plan as required. An SSD Progress Note, dated 2/13/25, indicated a referral for the resident was sent to another SNF. The SNF indicated they would not accept him unless he had Medicaid. The SSD called a second SNF, the resident had previously been referred to, and they declined to admit the resident because they do not feel he would be a good fit. The SSD spoke with the resident's sister and advised she proceed with getting Medicaid for him. The note lacked documentation the resident's sister was provided information or education on how to apply for Medicaid or the option to pay privately if desired, a reason the resident was referred to another SNF, what care or services the other SNF could provide that could not be provided at the facility, or documentation a 30 day notice of discharge was issued or discussed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SSD Progress Note, dated 3/6/25, indicated the resident's sister requested another referral be sent to a SNF the resident had previously been referred to. The SSD explained to the resident's sister the referral could be sent, but they had already declined to admit the resident a few weeks ago. The SSD explained to the resident's sister that the resident is running out of Medicare days and since he did not have Medicaid it would have been difficult to find placement. The resident's sister stated she did not know how to apply for Medicaid for him, and the SSD educated the resident's sister regarding the facility's Medicaid Done Right program and advised the representative would be at the facility the next day if she wanted to talk to her. The SSD advised the resident's sister that the resident only had a handful of Medicare days remaining. The resident's sister got flustered and stated she was not able to take care of the resident at home, and it would not be safe for him to discharge home with her. The resident's sister's goal was for him to live closer to her in a facility. The note lacked documentation the resident's sister was assisted with making an appointment with the Medicaid Done Right representative or a 30 day notice of discharge was issued or discussed. The Progress Notes lacked documentation the secondary payor source issue was addressed prior to 3/6/25, despite the resident being admitted to the facility with only a Medicare Advantage plan and a plan to stay long-term or a 30 day notice of discharge was issued when the facility determined the resident would be discharged on [DATE]. An SSD Progress Note, dated 3/7/25, indicated the resident was referred to another SNF. The note lacked documentation regarding why the resident was referred to another SNF, what care or services the other SNF could provide that could not be provided at the facility, or that a 30 day notice of discharge was issued. An SSD Progress Note, dated 3/11/25, indicated, SSD spoke with Resident's sister and advised that NOMNC [Notice of Medicare Non-Coverage] [notice Medicare will not pay for further care issued 48 hours prior to cut] was issued today, and that Resident will be discharged on Friday. Resident reported that he would like to go to a hotel. Resident also reports that he does not want to go live with his sister. However, when sister was contacted, she stated that she will not take him to a hotel, she will take him home. She was advised to pick him up by 9am on 3/13. She voiced understanding. The note lacked documentation the resident or his family were given options, other than immediate discharge, when the NOMNC was issued, despite the resident's record indicating he planned to stay in the facility long-term from the time of his admission. The note lacked documentation the resident's sister was notified of their right to appeal the Medicare Advantage plan's decision to cut the resident's skilled stay or that a 30 day notice of discharge was issued despite the fact that the facility told the family the resident was to be discharged from the facility on 3/14/25. An SSD Progress Note, dated 3/11/25, indicated the resident was referred to another SNF, but they could not accept the resident due to unspecified reasons. The note lacked documentation regarding why the resident was referred to another SNF including what care or services the other SNF could provide that could not be provided at the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SSD Progress Note, dated 3/11/25, indicated the SSD and Assistant Director of Nursing (ADON) had a phone meeting with the resident's family. They explained that a NOMNC had been issued, and the resident did not have another way of paying for nursing care. They explained to the resident's family that the resident was his own person, and if he wanted to discharge to a motel that was his right. The family continued to state that was not what they wanted. They reached a compromise for the resident to discharge to a motel in [redacted town name] near where his sister lived and had a McDonald's nearby. The resident would be referred to home health care. The note lacked documentation a 30 day notice of discharge was issued despite the facility telling the resident's family he was required to be discharged after he was cut from his Medicare Advantage plan. A NOMNC, dated 3/11/25, was signed by the resident. The last covered day of skilled nursing services was 3/13/25. A Business Office Manager (BOM) Note, dated 3/11/25 at 8:36 a.m., indicated, Resident sister .met with MDR [Medicaid Done Right] on 3/7 to discuss the medicaid pending process. [Resident's sister] answered MDR questions regarding resident financial status, however resident is over resourced by several thousand dollars, and will need to establish a [NAME] Trust due to the amount of monthly income. Sister requested with MDR to become resident POA [Power of Attorney]. MDR rep [representative] printed POA documentation and presented it to resident for signature. Resident refused to sign POA documentation and sister refused to allow MDR to pursue Medicaid. The note lacked documentation a 30 day notice of discharge was issued to the resident or his representative. A BOM Note, dated 3/11/25 at 11:48 a.m., indicated, BOM and SSD spoke with resident regarding issuance of NOMNC. Explained that it means he can go home on Friday, 3/14/25. Resident stated he doesn't have a place to go, but he does not want to go to his sister's. Resident stated he used to live in a motel and would like another one, but close to a McDonalds. SSD stated she would begin to look for a motel for him near a McDonalds by Friday. Resident voiced his understanding of discharge on Friday and us looking for a place. He seemed very excited to learn that he gets to leave the facility soon. The note lacked documentation the resident's right to appeal the decision for his Medicare Advantage plan to end his skilled services was explained to him, or other options were explained to him, such as privately paying or applying for Medicaid. The note did not indicate whether or not the resident wanted to appeal. The note lacked documentation a 30 day notice of discharge was issued to the resident or his representative. Email communication from the BOM, dated 3/11/25, indicated the resident was issued a NOMNC and was not appealing. The communication did not indicate if the resident's right to appeal was explained to him or if he understood it. The communication did not indicate a 30 day notice of discharge was issued to the resident or his representative. An edited SSD Progress Note, dated 3/13/25, indicated she placed a call to the resident's sister to advise her the resident could not safely discharge to a motel due to home health care denials. The SSD advised the resident's sister the resident may have been eligible for home health care if he discharged to the sister's home. The sister indicated she was not able to take him home, and the resident did not want to go home with her. SSD indicated she spoke with the Director of Nursing (DON) and a discharge planning care conference needed to take place on 3/14/25 with the resident, nursing, and social services. The note lacked documentation a 30 day notice of discharge was issued to the resident or his representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated discharge timeline for Resident B was provided by the interim DON on 3/14/25 at 10:49 a.m. The timeline indicated the resident was admitted to the facility on [DATE] and planned to stay long-term. On 2/7/25, the resident stated he planned to go home with his sister, but his sister stated he was staying at the facility long-term. On 2/11/25, the resident's sister requested he be referred to another SNF for long-term care that was closer to her. On 2/13/25, the resident's sister requested the resident be referred to two other SNFs in a town closer to her. On 3/6/25, there was a Medicaid meeting with the resident's sister, but he did not qualify for Medicaid due to assets and her unwillingness to participate. The resident's goal remained to stay at the facility long-term. On 3/7/25, the resident's sister requested the resident be referred again to one of the SNFs he was previously referred to so she would not have to take him home. On 3/11/25, the resident's NOMNC was issued, and he planned to discharge on 3/14/25. The resident stated he wanted to go to a motel, not with his sister. Six home health companies declined to admit the resident. The resident's sister stated she did not want to take him home, but she would come to the facility at 9:00 a.m. on 3/13/25 to arrange the home health. Nursing had the discharge on hold due to it was unsafe until home health was involved. The timeline lacked documentation a 30 day notice of discharge was issued to the resident or his representative. An untitled document, dated 3/14/25, was provided by the interim DON. At the same time, the DON indicated the document showed nursing put Resident B's discharge on hold for safety reasons. The document indicated, [Resident B] - Discharging 3/14 - Sister advised that he cannot safely discharge to a motel. SSD suggested she take him home and we make home health referrals again. Sister continues to state that she cannot take him home but plans to be here at 9am [sic]. We can get home health if she takes home The document did not indicate nursing assessed the safety of the resident's discharge and instead indicated the resident's sister had concerns regarding his planned discharge to a motel. The document did not indicate the resident's discharge was not going to happen that same day or that a 30 day notice of discharge was issued to the resident or his representative. A transportation schedule indicated it was dated Friday, March 13th 2025. The document indicated Resident B was discharged to a motel in Rockville. The document included the name, address, and phone number of the motel. During an interview, on 3/14/25 at 10:02 a.m., the interim DON indicated the transportation schedule was subject to change. She was not sure why a 30 day notice had not been issued or when discharge planning started. During an interview, on 3/14/25 at 10:49 a.m., the Administrator indicated the resident's sister was not willing to pay privately. There was a meeting scheduled with the resident's sister at 9:00 a.m. today, but she had not shown up to the facility. If the sister did not come to the meeting then a 30 day notice would have probably been issued that day. They would not have rolled the resident out onto the street. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/25 at 11:25 a.m., Medicaid Done Right Representative 8 indicated they provided a contracted service to the facility to help residents apply for Medicaid. The representative indicated she met with Resident B's sister on 3/7/25. The resident's sister dropped in to ask questions, and the meeting was not set up by the facility. Normally, when the facility assisted someone with payor source issues the facility scheduled a meeting with Medicaid Done Right to help with applying for Medicaid. Prior to a scheduled meeting, the residents would have been screened and she would have requested documents to be brought to the appointment. Since this was not a scheduled meeting, this preparation was not done, so she was only able to answer questions as asked by the resident's sister. The resident's sister told the representative the resident had money in an account which was over the amount he was allowed to have on Medicaid. The resident's sister said she would have been willing to pay privately at a different facility, but she did not want to pay privately at this facility. The representative called a couple of other SNFs to assist the resident's sister, but one declined to admit him because he had an unpaid bill there, and the other expressed some interest if he paid privately, but it needed followed up on. She was not sure if anyone followed up with the SNF that was potentially willing to admit him if he paid privately. She thought the resident was not referred to Medicaid Done Right earlier because he had not planned to stay at the facility long-term. She was not aware the resident reported intending to stay long-term at the facility when he was admitted . During an interview, on 3/14/25 at 1:21 p.m., the Nurse Consultant indicated the resident had a Medicare Advantage plan, and it had cut his skilled stay days. They tried to refer him to other facilities, but he was denied. The resident wanted to go to a motel because he lived in one before. The SSD planned to discharge him to a motel, but the rest of the Interdisciplinary team (IDT) was not aware of this. The SSD was uncertain how to handle a resident who had payor source issues and did not know the resident was allowed to stay past his last covered day. They should have started discussing the resident's discharge plan with the IDT when the Medicare Advantage plan cut him, but this had not occurred. They discussed the potential discharge as an IDT for the first time, on 3/13/25. She was not sure why his name was on the schedule as a planned discharge today. During a follow-up interview, on 3/14/25 at 1:51 p.m., Resident B's family member indicated she was not told about any meeting today for the resident's potential discharge. She had been at the facility earlier in the day, and no one had talked to her about the resident's discharge plan. She was not aware the resident had a right to appeal the decision of his Medicare Advantage plan to cut his skilled days. The resident required 24-hour care and could not take care of himself. The resident's sister indicated the SSD told her the resident's Medicare Advantage plan was not paying anymore, and he would need to discharge because, It's business. The SSD met with the resident by himself and did not include the resident's family member in the meeting so she is unsure exactly what was said. The resident told her his insurance was not paying anymore so he was being released. The resident thought he was able to take care of himself, but he was not able to. The family member indicated the resident exhibited confusion at times. Neither she, nor the resident, had been issued a 30 day notice of discharge. During an interview, on 3/14/25 at 2:33 p.m., the SSD indicated she issued NOMNCs when requested. They covered the appeals process, and most people opted to appeal. The resident refused to appeal the discharge because he was so excited about discharging somewhere close to a McDonalds and he didn't really hear what I was saying. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 2:50 p.m., the Nurse Consultant provided a document titled, Transfer/Discharge Notice, last revised on 2/3/25, and indicated it was the policy currently being used by the facility. The policy indicated, . Policies: The facility is committed to ensuring that all transfers and discharges are conducted in a manner that respects the rights, dignity, and welfare of residents while complying with federal and state regulations. This policy establishes procedures to ensure appropriate notice, documentation, and support for safe and orderly transitions .8. Timing of the Notice: a .the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged .9. Contents of the Notice: a. The reason for transfer or discharge; b. The effective date of transfer or discharge; c. The location to which the resident is transferred or discharged ; d. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; e. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman This citation relates to Complaint IN00455442. 3.1-12(a)(7)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38847 Based on interview, observation, and record review, the facility failed to plan for, and ensure the resident was prepared for, a safe and orderly discharge from the facility for a resident with significant clinical needs including catheter care, oxygen use, and wound care for 1 of 3 residents reviewed for discharges (Resident B). Findings include: During an interview, on 3/14/25 at 9:30 a.m., Qualified Medication Aide (QMA) 5 indicated she was working the unit Resident B resided on. He was discharging from the facility today, but she was not sure what time. QMA 5 indicated she was not sure where the resident planned to discharge, but the Social Services Director (SSD) should know. During an observation, on 3/14/25 at 9:33 a.m., Resident B was lying in bed with 3.5 liters (L) of oxygen via nasal cannula, and a catheter drainage bag was hanging on the side of the bed. At the same time, the resident indicated they have something planned but was unable to say what when asked if he planned to discharge from the facility that day. The resident did not know the year or who the president was. The resident's facial hair was untrimmed, and there was food on his chin. The resident indicated he did not care where he lived, and thought they might send him back to a motel. The resident denied requesting to discharge to a motel. He was not sure if he had Medicaid to pay for him to stay longer at the facility. The resident reported being unsure if he had a catheter and reached towards his groin area to check when asked. The resident was unable to verbalize how to care for his catheter, how much oxygen he required, how to turn the oxygen on and off, or how to apply the nasal cannula. During an interview, on 3/14/25 at 9:40 a.m., Resident B's family member indicated the facility notified her they planned to discharge Resident B to a motel because that was where he requested to go. The family member indicated the resident was not safe to discharge to a motel because he was unable to take care of himself. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Terre Haute	3500 Maple Ave Terre Haute, IN 47804

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/25 at 9:46 a.m., the SSD indicated Resident B's discharge had been postponed because no home health care company would accept him as a patient if he resided in a motel. The SSD indicated she was not aware or involved with residents who might have payor issues, based on a lack of a secondary payor, until it came time for them to discharge. She was not sure what plans were discussed related to potential payor issues when the resident's Medicare Advantage plan cut his skilled stay, prior to her first conversation with the resident's family. She first discussed Resident B's potential discharge with his family member on 3/6/25. The family member requested a referral be sent to another skilled nursing facility (SNF) because the family thought it was just a Medicare issue. The other SNF declined to admit the resident. The SSD did not indicate she attempted to provide education to the resident or family that the resident's Medicare Advantage plan would not pay for another SNF after he was cut from their facility's skilled stay. The SSD did not indicate she discussed other options with the resident or family, such as paying privately, planning a realistically safe discharge, or Medicaid. The SSD was not sure if the resident was able to take care of his catheter and oxygen or if supplies had been set up for his discharge. The SSD indicated nursing should have addressed the catheter and oxygen, but she was unable to provide information or documentation the care needs had been addressed as part of the discharge process. The SSD indicated discharge planning should have started on day one of the resident's admission to the facility, and she was the discharge coordinator, but she was unable to provide documentation the resident's payor issues or discharge had been discussed with the resident or family prior to 3/6/25. During an interview, on 3/14/25 at 9:52 a.m., Certified Nurse Aide (CNA) 6 indicated she was working the unit Resident B resided on. Resident B was sometimes alert and oriented but had some confusion. The resident needed one staff member to assist him with getting dressed, and two staff members with a Hoyer (mechanical lift) to get out of bed. The resident was not able to stand well. He sometimes got out of bed but not everyday. The resident would not have been able to get up, get dressed, and take care of himself if he lived alone in a motel. CNA 6 indicated the resident was scheduled to be discharged from the facility today, and she provided a paper schedule which indicated the resident was discharged to a motel, including the motel's name, address, and phone number. CNA 6 was not aware Resident B's discharge was postponed. During an interview, on 3/14/25 at 9:54 a.m., CNA 7 indicated she was familiar with Resident B and was working the unit he resided on. The resident needed the assistance of two staff members to get out of bed and recently they had started to use the Hoyer lift to get him up. The resident was incontinent of bowels. CNA 7 indicated Resident B would have been unable to take care of himself if he lived on his own. The resident had not ever completed his own catheter or oxygen care. The resident was pretty confused and was unable to understand things, such as why his knee hurt even though he recently had knee surgery. The resident usually wore a hospital gown. Resident B was scheduled to discharge from the facility today, and she was not aware of the discharge being postponed. Resident B's record was reviewed on 3/14/25 at 11:10 a.m. Census information indicated the resident was admitted to the facility on [DATE] with a Medicare Advantage plan payor, and there was no secondary, or back-up, payor. The resident's payor type changed to private pay on 3/14/25. Diagnoses on the resident's profile included, but were not limited to, sepsis (life-threatening condition when the body overreacts to an infection), unspecified osteomyelitis (bone infection), unspecified protein-calorie malnutrition, generalized muscle weakness, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD) (group of lung diseases causing breathing difficulties). (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 1/26/25, indicated Foley catheter care every shift. A Care Conference Observation, dated 1/27/25, indicated the resident and the SSD attended the meeting, and the resident planned on staying in the facility long-term. The document did not indicate the SSD discussed with the resident options regarding what would happen when his Medicare Advantage plan cut the resident from the skilled stay since he planned to remain in the facility. There was no documentation of a plan for a secondary payor source once the Medicare Advantage plan stopped paying. An admission Minimum Data Set (MDS) assessment, dated 1/28/25, indicated the resident was cognitively intact. He required substantial/maximal staff assistance with toileting, showering/bathing, lower body dressing, putting on and taking off footwear, bed to chair transfers, toilet transfers, and tub and shower transfers. The resident required partial/moderate assistance with upper body dressing, personal hygiene, and rolling left and right. The resident had an indwelling catheter and was always incontinent of his bowels. The resident was at risk for pressure ulcers but had no pressure ulcers. The resident participated in the assessment process. The overall goal for discharge established during the assessment process was for the resident to stay in the facility long-term, and this information came from the resident's family. The assessment also indicated active discharge planning was in process for the resident to return to the community. A Physician's Order, dated 1/28/25, indicated the resident required staff assistance with bed mobility, transfers, and toileting due to shortness of breath related to COPD. A care plan, initiated on 1/29/25, indicated the resident had a self care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of activities of daily living (ADLs). A care plan, initiated on 2/1/25, indicated the resident had cognitive loss/dementia and had impaired cognitive skills as evidenced by the brief interview for mental status (BIMS) score (cognition assessment). A Progress Note, dated 2/3/25, indicated the resident's sister called the corporate compliance line with concerns of call light response timeliness and skilled services. The resident's sister came to the facility, and they met with the resident. The resident had some cognitive impairment and lapsed between showing understanding and answering questions appropriately to drifting off into nonsensical conversations. The resident was concerned that the facility allowed smoking, but he was required to be up in the wheelchair and propel himself to smoke. The resident previously lived in an infested motel. A care plan, initiated on 2/4/25, indicated the resident planned to discharge to the community. Interventions indicated arrange for medical equipment upon discharge, assist the resident with transportation as needed, discuss the discharge planning process with the resident and family, observe and report to the physician any changes in mood, behavior, cognition, and level of functioning caused by situational stressor and anticipated discharge, observe for psychosocial changes, provide the resident and/or representative with education as needed, provide services according to care plans in an effort to enhance optimum well-being and prevent hospitalization s, and secure any required state or insurance approval for transfer. The resident's record lacked documentation medical equipment was arranged in preparation of discharge or education was provided as indicated in the care plan as required. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SSD Progress Note, dated 2/13/25, indicated a referral for the resident was sent to another SNF. The SNF indicated they would not accept him unless he had Medicaid. The SSD called a second SNF, the resident had previously been referred to, and they declined to admit the resident because they do not feel he would be a good fit. The SSD spoke with the resident's sister and advised she proceed with getting Medicaid for him. The note lacked documentation the resident's sister was provided information or education on how to apply for Medicaid or the option to pay privately if desired, a reason the resident was referred to another SNF, or what care or services the other SNF could provide that could not be provided at the facility. A Physician's Order, dated 2/17/25, indicated cleanse wound on right upper buttock with wound cleanser, apply Medihoney (dressing that aides in wound healing) to wound bed, skin prep (creates a barrier between skin and dressing) around the wound, and cover with bordered gauze daily and as need if soiled or dislodged. A care plan, initiated on 2/18/25, indicated the resident had an alteration in voiding related to the placement of a Foley catheter. Interventions included, but were not limited to, empty catheter bag every shift and as needed and catheter care every shift and as needed. The care plan did not indicate the resident was able to, or was educated how to, empty the catheter bag or complete catheter care in preparation for discharge. A care plan, initiated on 2/25/25, indicated the resident had a pressure ulcer to the right inner buttock. Interventions included, but were not limited to, treatments provided per the physician's order. The care plan did not indicate the resident was able to, or was educated how to, complete treatments to the pressure ulcer in preparation for discharge. A care plan, initiated on 2/25/25, indicated the resident had a pressure ulcer to the right lower buttock. Interventions included, but were not limited to, treatments provided per the physician's order. The care plan did not indicate the resident was able to, or was educated how to, complete treatments to the pressure ulcer in preparation for discharge. A care plan, initiated on 2/28/25, indicated the resident required oxygen. Interventions included, but were not limited to, oxygen provided as ordered. The care plan did not indicate the resident was able to, or educated was on how to, self-administer oxygen in preparation for discharge. A Daily Skilled Note Observation, dated 3/1/25, included a box to check if discharge planning education was provided and a box to check if education was provided for the resident's treatment or condition. Neither box was checked to indicate the education was provided. Two Daily Skilled Note Observations were dated 3/2/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. A Daily Skilled Note Observation was dated 3/4/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. Two Daily Skilled Note Observations were dated 3/5/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Daily Skilled Note Observation was dated 3/6/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. An SSD Progress Note, dated 3/6/25, indicated the resident's sister requested another referral be sent to a SNF the resident had previously been referred to. The SSD explained to the resident's sister the referral could be sent, but they had already declined to admit the resident a few weeks ago. The SSD explained to the resident's sister that the resident is running out of Medicare days and since he did not have Medicaid it would have been difficult to find placement. The resident's sister stated she did not know how to apply for Medicaid for him, and the SSD educated the resident's sister regarding the facility's Medicaid Done Right program and advised the representative would be at the facility the next day if she wanted to talk to her. The SSD advised the resident's sister that the resident only had a handful of Medicare days remaining. The resident's sister got flustered and stated she was not able to take care of the resident at home, and it would not be safe for him to discharge home with her. The resident's sister's goal was for him to live closer to her in a facility. The note lacked documentation the resident's sister was assisted with making an appointment with the Medicaid Done Right representative. The Progress Notes lacked documentation the secondary payor source issue was addressed prior to 3/6/25, despite the resident being admitted to the facility with only a Medicare Advantage plan and a plan to stay long-term. A Daily Skilled Note Observation was dated 3/7/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. An SSD Progress Note, dated 3/7/25, indicated the resident was referred to another SNF. The note lacked documentation regarding why the resident was referred to another SNF including what care or services the other SNF could provide that could not be provided at the facility. A Daily Skilled Note Observation was dated 3/8/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. Two Daily Skilled Note Observations were dated 3/9/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. An SSD Progress Note, dated 3/11/25, indicated, SSD spoke with Resident's sister and advised that NOMNC [Notice of Medicare Non-Coverage] [notice Medicare will not pay for further care issued 48 hours prior to cut] was issued today, and that Resident will be discharged on Friday. Resident reported that he would like to go to a hotel. Resident also reports that he does not want to go live with his sister. However, when sister was contacted, she stated that she will not take him to a hotel, she will take him home. She was advised to pick him up by 9am on 3/13. She voiced understanding. The note lacked documentation the resident or his family were given options, other than immediate discharge, when the NOMNC was issued, despite the resident's record indicating he planned to stay in the facility long-term from the time of his admission. The note lacked documentation the resident's sister was notified of their right to appeal the Medicare Advantage plan's decision to cut the resident's skilled stay. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SSD Progress Note, dated 3/11/25, indicated the resident was referred to another SNF, but they could not accept the resident due to unspecified reasons. The note lacked documentation regarding why the resident was referred to another SNF including what care or services the other SNF could provide that could not be provided at the facility. An SSD Progress Note, dated 3/11/25, indicated the SSD and Assistant Director of Nursing (ADON) had a phone meeting with the resident's family. They explained that a NOMNC had been issued, and the resident did not have another way of paying for nursing care. They explained to the resident's family that the resident was his own person, and if he wanted to discharge to a motel that was his right. The family continued to state that was not what they wanted. They reached a compromise for the resident to discharge to a motel in [redacted town name] near where his sister lived and had a McDonald's nearby. The resident would be referred to home health care. The note lacked documentation there was a plan discussed to obtain required medical supplies or education provided for the resident's clinical needs. A Daily Skilled Note Observation was dated 3/11/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. A NOMNC, dated 3/11/25, was signed by the resident. The last covered day of skilled nursing services was 3/13/25. A Business Office Manager (BOM) Note, dated 3/11/25 at 8:36 a.m., indicated, Resident sister .met with MDR [Medicaid Done Right] on 3/7 to discuss the medicaid pending process. [Resident's sister] answered MDR questions regarding resident financial status, however resident is over resourced by several thousand dollars, and will need to establish a [NAME] Trust due to the amount of monthly income. Sister requested with MDR to become resident POA [Power of Attorney]. MDR rep [representative] printed POA documentation and presented it to resident for signature. Resident refused to sign POA documentation and sister refused to allow MDR to pursue Medicaid. A BOM Note, dated 3/11/25 at 11:48 a.m., indicated, BOM and SSD spoke with resident regarding issuance of NOMNC. Explained that it means he can go home on Friday, 3/14/25. Resident stated he doesn't have a place to go, but he does not want to go to his sisters. Resident stated he used to live in a motel and would like another one, but close to a McDonalds. SSD stated she would begin to look for a motel for him near a McDonalds by Friday. Resident voiced his understanding of discharge on Friday and us looking for a place. He seemed very excited to learn that he gets to leave the facility soon. The note lacked documentation the resident's right to appeal the decision for his Medicare Advantage plan to end his skilled services was explained to him, or other options were explained to him, such as privately paying or applying for Medicaid. The note did not indicate whether or not the resident wanted to appeal or that nursing was notified of the impending discharge to prepare for his clinical needs. Email communication from the BOM, dated 3/11/25, indicated the resident was issued a NOMNC and was not appealing. The communication did not indicate if the resident's right to appeal was explained to him or if he understood it. An edited SSD Progress Note, dated 3/12/25, indicated five home health care companies declined to admit the resident. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Daily Skilled Note Observation was dated 3/12/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. An edited SSD Progress Note, dated 3/13/25, indicated she placed a call to the resident's sister to advise her the resident could not safely discharge to a motel due to home health care denials. The SSD advised the resident's sister the resident may have been eligible for home health care if he discharged to the sister's home. The sister indicated she was not able to take him home, and the resident did not want to go home with her. SSD indicated she spoke with the Director of Nursing (DON) and a discharge planning care conference needed to take place on 3/14/25 with the resident, nursing, and social services. A Daily Skilled Note Observation was dated 3/13/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. A Daily Skilled Note Observation was dated 3/14/25. The boxes for the provision of discharge planning education and education for the resident's treatment or condition were not checked. An undated discharge timeline for Resident B was provided by the interim DON on 3/14/25 at 10:49 a.m. The timeline indicated the resident was admitted to the facility on [DATE] and planned to stay long-term. On 2/7/25, the resident stated he planned to go home with his sister, but his sister stated he was staying at the facility long-term. On 2/11/25, the resident's sister requested he be referred to another SNF for long-term care that was closer to her. On 2/13/25, the resident's sister requested the resident be referred to two other SNFs in a town closer to her. On 3/6/25, there was a Medicaid meeting with the resident's sister, but he did not qualify for Medicaid due to assets and her unwillingness to participate. The resident's goal remained to stay at the facility long-term. On 3/7/25, the resident's sister requested the resident be referred again to one of the SNFs he was previously referred to so she would not have to take him home. On 3/11/25, the resident's NOMNC was issued, and he planned to discharge on 3/14/25. The resident stated he wanted to go to a motel, not with his sister. Six home health companies declined to admit the resident. The resident's sister stated she did not want to take him home, but she would come to the facility at 9:00 a.m. on 3/13/25 to arrange the home health. Nursing had the discharge on hold due to it was unsafe until home health was involved. An untitled document, dated 3/14/25, was provided by the interim DON. At the same time, the DON indicated the document showed nursing put Resident B's discharge on hold for safety reasons. The document indicated, [Resident B] - Discharging 3/14 - Sister advised that he cannot safely discharge to a motel. SSD suggested she take him home and we make home health referrals again. Sister continues to state that she cannot take him home but plans to be here at 9am [sic]. We can get home health if she takes home The document did not indicate nursing assessed the safety of the resident's discharge and instead indicated the resident's sister had concerns regarding his planned discharge to a motel. The document did not indicate the resident's discharge was not going to happen that same day. A transportation schedule indicated it was dated Friday, March 13th 2025. The document indicated Resident B was discharged to a motel in Rockville. The document included the name, address, and phone number of the motel. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/25 at 10:02 a.m., the interim DON indicated the transportation schedule was subject to change. She was not sure why a 30 day notice had not been issued or when discharge planning started. During an interview, on 3/14/25 at 10:49 a.m., the Administrator indicated the resident's sister was not willing to pay privately. There was a meeting scheduled with the resident's sister at 9:00 a.m. today, but she had not shown up to the facility. If the sister did not come to the meeting then a 30 day notice would have probably been issued that day. They would not have rolled the resident out onto the street. At the same time, the interim DON indicated she was not sure if catheter or oxygen supplies and education had been addressed, but home health would have addressed these needs if they had found a company to admit him. The resident started using a Hoyer lift for transfers one or two weeks ago. She was not sure if the addition of the Hoyer lift changed or adjusted the resident's discharge plans. She was not able to provide documentation the resident had been provided education and training regarding his catheter, oxygen, or wound care, or supplies were addressed in preparation for the resident's discharge. During an interview, on 3/14/25 at 11:25 a.m., Medicaid Done Right Representative 8 indicated they provided a contracted service to the facility to help residents apply for Medicaid. The representative indicated she met with Resident B's sister on 3/7/25. The resident's sister dropped in to ask questions, and the meeting was not set up by the facility. Normally, when the facility assisted someone with payor source issues the facility scheduled a meeting with Medicaid Done Right to help with applying for Medicaid. Prior to a scheduled meeting, the residents would have been screened and she would have requested documents to be brought to the appointment. Since this was not a scheduled meeting, this preparation was not done, so she was only able to answer questions as asked by the resident's sister. The resident's sister told the representative the resident had money in an account which was over the amount he was allowed to have on Medicaid. The resident's sister said she would have been willing to pay privately at a different facility, but she did not want to pay privately at this facility. The representative called a couple of other SNFs to assist the resident's sister, but one declined to admit him because he had an unpaid bill there, and the other expressed some interest if he paid privately, but it needed followed up on. She was not sure if anyone followed up with the SNF that was potentially willing to admit him if he paid privately. She thought the resident was not referred to Medicaid Done Right earlier because he had not planned to stay at the facility long-term. She was not aware the resident reported intending to stay long-term at the facility when he was admitted . During an interview, on 3/14/25 at 1:21 p.m., the Nurse Consultant indicated the resident had a Medicare Advantage plan, and it had cut his skilled stay days. They tried to refer him to other facilities, but he was denied. The resident wanted to go to a motel because he lived in one before. The SSD planned to discharge him to a motel, but the rest of the Interdisciplinary team (IDT) was not aware of this. The SSD was uncertain how to handle a resident who had payor source issues and did not know the resident was allowed to stay past his last covered day. The SSD was the discharge planner and should have assisted with medical supplies, training, and ensuring a safe discharge. The should have started discussing the resident's discharge plan with the IDT when the Medicare Advantage plan cut him, but this had not occurred. They discussed the potential discharge as an IDT for the first time, on 3/13/25. She was not sure why his name was on the schedule as a planned discharge today. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview, on 3/14/25 at 1:51 p.m., Resident B's family member indicated she was not told about any meeting today for the resident's potential discharge. She had been at the facility earlier in the day, and no one had talked to her about the resident's discharge plan. She was not aware the resident had a right to appeal the decision of his Medicare Advantage plan to cut his skilled days. The resident required 24-hour care and could not take care of himself. The resident's sister indicated the SSD told her the resident's Medicare Advantage plan was not paying anymore, and he would need to discharge because, It's business. The SSD met with the resident by himself and did not include the resident's family member in the meeting so she is unsure exactly what was said. The resident told her his insurance was not paying anymore so he was being released. The resident thought he was able to take care of himself, but he was not able to. The family member indicated the resident exhibited confusion at times. During an interview, on 3/14/25 at 2:33 p.m., the SSD indicated she issued NOMNCs when requested. They covered the appeals process, and most people opted to appeal. The resident refused to appeal the discharge because he was so excited about discharging somewhere close to a McDonalds and he didn't really hear what I was saying. On 3/14/25 at 2:50 p.m., the Nurse Consultant provided a document titled, Transfer/Discharge Notice, last revised on 2/3/25, and indicated it was the policy currently being used by the facility. The policy indicated, Policies: The facility is committed to ensuring that all transfers and discharges are conducted in a manner that respects the rights, dignity, and welfare of residents while complying with federal and state regulations. This policy establishes procedures to ensure appropriate notice, documentation, and support for safe and orderly transitions .'Discharge Planning': A process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge .5. Discharge Planning Process. The facility's discharge planning process must: a. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. b. 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. c. Involve the Interdisciplinary team in the ongoing process of developing the discharge plan. d. Involve the resident and resident representative in development of the discharge plan and inform the resident and resident representative of the final plan. e. Consider the 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. f. Address the resident's goals of care and treatment preferences. g. Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance This citation relates to Complaint IN00455442. 3.1-12(a)(21)