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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255314	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	1920 Lisa Drive Extended Greenville, MS 38703

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on resident representative and staff interview, record review and facility policy review the facility failed to honor a resident's right to return to the facility following a hospitalization for one (1) of three (3) residents reviewed for discharge. Resident #1. Findings Include: Record review of facility policy titled, Discharge Transfer and Planning , revised 9/23, revealed The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility . Before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand .The Discharge/Transfer notice shall be made by the facility at least 30 days before the resident is transferred or discharged . Record review of the Face Sheet for Resident #1 revealed that the facility admitted him on 12/24/2013 with diagnoses that included Cerebral Infarction and Alzheimer's Disease. The facility discharged Resident #1 on 6/7/2024. (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: 255314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Washington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1920 Lisa Drive Extended Greenville, MS 38703	

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview with Resident Representative #2 on 7/1/24 at 11:15 AM, she stated that on 6/7/24 she was notified by the hospital social worker that Resident #1 was being discharged from the hospital on that day but that the facility refused to take him back because he had exceeded his bed hold and that the family had fired the attending physician. Resident Representative #2 stated that the family never fired the resident's attending physician. She stated that at the hospital another physician was filling in for the attending physician there and they thought the attending physician would resume care when Resident #1 returned to the facility. Resident Representative #2 stated that after the initial call they received on 5/23/24 when the resident was being sent to the hospital, they received no other communication from the facility until 6/10/24 when she and Resident Representative #1 initiated contact. Resident Representative #2 stated that they were never notified by the facility that the attending physician would no longer be Resident #1's physician in the nursing home or that Resident #1 was being discharged from the facility. She stated they never received a discharge notification or the opportunity to appeal the discharge. Resident Representative #2 stated that on 6/10/24 she asked Resident Representative #1 to go to the facility to find out what the issue was. She stated that a conference was held on 6/10/24 between Resident Representative #1, Resident Representative #2, the Administrator and the Director of Nursing (DON). She stated that at that time they were told by the facility that the resident exceeded his bed hold days, so he had to be discharged and he did not have a physician to readmit him. She reported that the facility did not offer to help them find an alternative physician telling them that the other physicians were not accepting new residents. She stated that the resident was discharged from the hospital to an alternative nursing home on 6/14/24 after he had lived in the nursing home for over [AGE] years. During an interview with the DON on 7/1/24 at 11:05 AM, she stated on 6/3/24, while the resident was still in the hospital, the facility received a call from the receptionist at Resident #1's attending physician's office notifying them that he would no longer be Resident #1's physician. She stated that she did not know what prompted this change. She verified that she did not reach out to the family to notify them or to attempt to find out what prompted this change. The DON stated on 6/5/24 she called another physician to see if he would be willing to accept Resident #1, but the physician was not accepting new residents. She stated she did not contact the two (2) physicians to inquire if they would be willing to admit Resident #1. She stated on 6/6/24 or 6/7/24 the hospital called regarding Resident #1's readmission to the nursing facility, and she informed them at that time that the resident did not have a physician so they would not be taking him back. An interview and record review on 7/1/24 at 11:15 AM, with the Administrator, of an untitled document, on facility letter head, addressed to Resident Representative #1 revealed This letter is to inform you of the facility-initiated discharge to hospital on 6/7/24 . we are no longer able to meet your needs in this facility and the transfer is necessary for your welfare. Additional comments: Resident exhausted his bed hold days. Discharge to Proper Name of Hospital effective date 6/7/24. The Administrator stated that the notification was mailed on 6/7/24 but was unable to provide documentation that the document had been delivered to the Resident Representative. An interview on 7/1/24 at 11:20 AM, with the Administrator verified that the facility did not contact Resident #1's family regarding the resident not having an attending physician or to notify them that he would be discharged and not readmitted to the facility. She also verified that the facility did not reach out to any of their other physicians to determine if they would accept the resident for admission.