

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER The Laurels of Hamilton		STREET ADDRESS, CITY, STATE, ZIP CODE 2923 Hamilton Mason Road Hamilton, OH 45011	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on closed medical record review, review of facility-initiated discharge notices, review of the discharge appeal hearing decision, staff interview, guardian interview, Hospital Social Worker (HSW) interview and review of facility policy, the facility failed to ensure an appropriate resident discharge. This affected one resident (#8601) of three residents reviewed for discharge. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #8601's medical record revealed an admitted [DATE]. Diagnoses included Huntington's disease, Alzheimer's disease with early onset, severe protein-calorie malnutrition and repeated falls. Further review revealed Resident #8601 was discharged on [DATE].</p> <p>Review of physician orders from orders from 08/01/24 to 09/19/24 revealed no discharge order for Resident #8601. Further review revealed a physician order, dated 08/28/24, to send Resident #8601 to the Emergency Department (ED) for further psychological evaluation, one time only, for further evaluation and treatment of physical aggression.</p> <p>Review of the facility-initiated discharge notice, dated 08/23/24, revealed a 30-day discharge notice was issued to Resident #8601 and the resident's guardian. The effective date of the discharge was identified as 09/21/24 and reasons for discharge included noncompliance with care, combativeness and posing a safety risk to himself and others. Further review revealed appropriate notification of the discharge was made to the Ombudsman and state agencies.</p> <p>Review of a progress note dated 08/28/24 revealed Resident #8601 was sent to the ED for further psychological evaluation per physician order. The psychological services provider completed an application for emergency admission (pink slip) and Resident #8601 was transported to the ED by Emergency Medical Services (EMS) with law enforcement escort. Further review of a progress note dated 08/28/24 revealed the hospital notified the facility Resident #8601 was ready to return. The Director of Nursing (DON) informed the ED nurse the facility would not accept the resident back.</p> <p>Review of a progress note dated 09/03/24 revealed the hospital notified the facility that Resident #8601 was ready to return. The facility made Resident #8601 and the resident's guardian aware the resident would not be accepted back to the facility.</p> <p>(continued on next page)</p>

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
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the discharge appeal hearing examiners decision and order, dated 09/05/24, revealed Resident #8601's guardian requested an emergency appeal of the resident's discharge and indicated the resident was in the hospital and the facility refused to accept him back. The document stated the facility did not attend the hearing. Further review of the appeal decision revealed the facility was not authorized to discharge Resident #8601 and was ordered to readmit the resident. A copy of the decision was sent via electronic mail (e-mail) to the Administrator on 09/06/24.</p> <p>Review of the facility-initiated emergency discharge notice, dated 09/12/24, revealed the notice was issued to Resident #8601 and his guardian. The discharge notice indicated the effective date of the discharge was 09/12/24 and the reasons for discharge included the safety of the individuals in the home was endangered, the resident's urgent medical needs necessitated a more immediate transfer or discharge and the welfare and needs of the resident could not be met at the facility. The notice did not include any specific information related to the discharge reasons indicated.</p> <p>Further review of Resident #8601's medical record revealed no specific documentation from the physician indicating what needs the facility could not meet for the resident to result in an emergency discharge.</p> <p>Interview on 09/16/24 at 2:50 P.M. with the Administrator, Social Worker (SW) #106 and Hospital Liaison (HL) #175 confirmed the hospital wanted to send Resident #8601 back to the facility on [DATE], but the facility refused readmission pending a neurological evaluation. As of 09/16/24, Resident #8601 remained in the hospital.</p> <p>A telephone interview on 09/17/24 at 2:09 P.M. with HSW #1001 and HSW #1002 confirmed on 08/28/24, the hospital attempted to return Resident #8601 to the facility following an ED evaluation; however, the facility refused to unlock the coded door to allow access and the resident was transported back to the hospital. On 09/12/24, after receiving the discharge appeal ruling from 09/05/24, the hospital attempted to have Resident #8601 readmitted to the facility, but the facility again refused readmission and the resident was transported back to the hospital. HSW #1002 stated the facilities identified on the facility-initiated discharge notices as the discharge location for Resident #8601 had never accepted the resident for admission. HSW #1001 and HSW #1002 denied the facility had any proactive conversations with them related to Resident #8601 not being accepted back to the facility.</p> <p>A telephone interview on 09/18/24 at 1:26 P.M. with Resident #8601's guardian revealed she was aware the facility was seeking alternative placement for the resident. However, the guardian stated she was unaware the facility was going to refuse to readmit the resident from the hospital. Resident #8601's guardian stated she learned from HSW #1001 that the facility would not allow the resident to return. The guardian stated there were several back and forth conversations with the facility from 08/28/24 through 09/05/24 related to Resident #8601 returning, with the facility stating they were not taking him back, they did not have to take him back and they would not let him in. The guardian stated the communications came from the Administrator, DON and SW #106. The guardian stated she received the same response from the facility on 09/12/24 when the hospital again attempted to discharge the resident back to the facility and he was refused readmission. The guardian stated even after the discharge appeal hearing on 09/05/24, which ordered the facility to readmit Resident #8601, the facility refused the resident's readmission.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on 09/19/24 at 9:10 A.M. with Licensed Practical Nurse (LPN) #425 revealed the psychological services Nurse Practitioner (NP) did not assess Resident #8601 before completing the pink-slip to send Resident #8601 to the hospital. LPN #425 stated the NP completed the pink slip and sent it to the facility via e-mail. At the time Resident #8601 was sent to the hospital, LPN #425 stated she was unaware the facility would not readmit the resident. During a meeting on 08/29/24, Regional Director of Operations (RDO) #500 decided Resident #8601 was being discharged immediately and would not return to the facility.</p> <p>A telephone interview on 09/20/24 at 2:12 P.M. with the Administrator confirmed on 08/28/24 at 8:34 P.M., text messages were exchanged between her, the DON, Registered Nurse (RN) #306, LPN #425 and HL #175 indicating Resident #8601 would not be readmitted to the facility. The Administrator confirmed RDO #500 made the decision not to readmit Resident #8601 and this decision was communicated to all department heads during the morning meeting on 08/29/24. Resident #8601 did not return to the facility, even after the discharge appeal hearing officer ordered the facility to readmit the resident.</p> <p>Review of the facility policy titled Transfer and Discharge, revised 03/26/24, revealed the transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. Further review revealed the facility may not transfer or discharge a resident while an appeal is pending unless the failure to discharge or transfer would endanger the resident or other individuals in the facility. In cases where the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, the documentation made by the resident's physician must include the specific resident needs the facility could not meet, the facility efforts to meet those needs and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the facility. If a resident's clinical or behavioral status (or condition) endangers the health or safety of individuals in the facility, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number OH00157356.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on closed medical record review, review of facility-initiated discharge notices, staff interviews and review of facility policy, the facility failed to ensure discharge notices were accurately completed. This affected one resident (#8601) of three residents reviewed for discharge. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #8601's medical record revealed an admitted [DATE]. Diagnoses included Huntington's disease, Alzheimer's disease with early onset, severe protein-calorie malnutrition and repeated falls. The resident was transferred to the hospital on 08/28/24.</p> <p>Review of the facility initiated 30-day discharge notice, dated 08/23/24, revealed a discharge notice was issued to Resident #8601 and his guardian. Appropriate notification was made to the Ombudsman and required state agencies. Further review of the discharge notice revealed the discharge was effective 09/21/24 and a specified nursing facility was identified as the discharge location for Resident #8601. Review of a progress note dated 08/19/24 revealed the facility identified as the discharge location for Resident #8601 denied the resident admission (four days prior to the facility identifying it as the discharge location for the resident).</p> <p>Review of the facility-initiated emergency discharge notice, dated 09/12/24, revealed an immediate discharge notice was issued to Resident #8601 and his guardian. Appropriate notification was made to the Ombudsman and required state agencies. The effective date of the discharge was 09/12/24 and a specified nursing facility was identified as the discharge location for Resident #8601.</p> <p>Interview on 09/16/24 at 2:50 P.M. with the Administrator and Social Worker (SW) #106 confirmed the facility had knowledge prior to issuing the 30-day discharge notice on 08/23/24 that the facility identified as the discharge location for Resident #8601 had already denied the resident admission. An updated discharge notice indicating Resident #8601 would not be discharged to the identified facility was not issued.</p> <p>A telephone interview on 09/20/24 at 10:54 A.M. with the Administrator verified the facility identified on the emergency discharge notice dated 09/12/24 as the discharge location for Resident #8601 had not accepted the resident for admission. An updated discharge notice indicating Resident #8601 would not be discharged to the identified facility was not issued.</p> <p>A follow-up telephone interview on 09/20/24 at 2:12 P.M. with the Administrator confirmed Resident #8601 was transferred to the hospital on 08/28/24, the facility did not readmit the resident and no alternative placement had been identified for the resident.</p> <p>Review of the facility policy titled Transfer and Discharge, revised 03/26/24, revealed the contents of the discharge notice must include the specific location to which the resident is being transferred or discharged (if a change in destination indicates that the original basis for discharge has changed, a new notice is required).</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on closed medical record review, review of facility-initiated discharge notices, review of the discharge appeal hearing decision, staff interview, guardian interview and Hospital Social Worker (HSW) interview, the facility failed to ensure a resident was readmitted to the facility upon discharge from the hospital. This affected one resident (#8601) of three residents reviewed for discharge. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #8601's medical record revealed an admitted [DATE]. Diagnoses included Huntington's disease, Alzheimer's disease with early onset, severe protein-calorie malnutrition and repeated falls. Further review revealed Resident #8601 was transferred to the hospital and discharged on [DATE].</p> <p>Review of physician orders from orders from 08/01/24 to 09/19/24 revealed no discharge order for Resident #8601. Further review revealed a physician order, dated 08/28/24, to send Resident #8601 to the Emergency Department (ED) for further psychological evaluation, one time only, for further evaluation and treatment of physical aggression.</p> <p>Review of the facility-initiated discharge notice, dated 08/23/24, revealed a 30-day discharge notice was issued to Resident #8601 and the resident's guardian. The effective date of the discharge was identified as 09/21/24 and reasons for discharge included noncompliance with care, combativeness and posing a safety risk to himself and others. Further review revealed appropriate notification of the discharge was made to the Ombudsman and state agencies.</p> <p>Review of a progress note dated 08/28/24 revealed Resident #8601 was sent to the ED for further psychological evaluation per physician order. The psychological services provider completed an application for emergency admission (pink slip) and Resident #8601 was transported to the ED by Emergency Medical Services (EMS) with law enforcement escort. Further review of a progress note dated 08/28/24 revealed the hospital notified the facility Resident #8601 was ready to return. The Director of Nursing (DON) informed the ED nurse the facility would not accept the resident back.</p> <p>Review of a progress note dated 09/03/24 revealed the hospital notified the facility that Resident #8601 was ready to return. The facility made Resident #8601 and the resident's guardian aware the resident would not be accepted back to the facility.</p> <p>Review of the discharge appeal hearing examiners decision and order, dated 09/05/24, revealed Resident #8601's guardian requested an emergency appeal of the resident's discharge and indicated the resident was in the hospital and the facility refused to accept him back. The document stated the facility did not attend the hearing. Further review of the appeal decision revealed the facility was not authorized to discharge Resident #8601 and was ordered to readmit the resident. A copy of the decision was sent via electronic mail (e-mail) to the Administrator on 09/06/24.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility-initiated emergency discharge notice, dated 09/12/24, revealed the notice was issued to Resident #8601 and his guardian. The discharge notice indicated the effective date of the discharge was 09/12/24 and the reasons for discharge included the safety of the individuals in the home was endangered, the resident's urgent medical needs necessitated a more immediate transfer or discharge and the welfare and needs of the resident could not be met at the facility. The notice did not include any specific information related to the discharge reasons indicated.</p> <p>Interview on 09/16/24 at 2:50 P.M. with the Administrator, Social Worker (SW) #106 and Hospital Liaison (HL) #175 confirmed the hospital wanted to send Resident #8601 back to the facility on [DATE], but the facility refused readmission pending a neurological evaluation. As of 09/16/24, Resident #8601 remained in the hospital and had not been permitted to return to the facility.</p> <p>A telephone interview on 09/17/24 at 2:09 P.M. with HSW #1001 and HSW #1002 confirmed on 08/28/24, the hospital attempted to discharge Resident #8601 back to the facility following an ED evaluation; however, the facility refused to unlock the coded door to allow access, and the resident was transported back to the hospital. On 09/12/24, after receiving the discharge appeal ruling from 09/05/24, the hospital attempted to have Resident #8601 readmitted to the facility, but the facility again refused readmission, and the resident was transported back to the hospital. HSW #1001 and HSW #1002 denied the facility had any proactive conversations with them related to Resident #8601 not being accepted back to the facility.</p> <p>A telephone interview on 09/18/24 at 1:26 P.M. with Resident #8601's guardian revealed she was aware the facility was seeking alternative placement for the resident. However, the guardian stated she was unaware the facility was going to refuse to readmit the resident from the hospital. Resident #8601's guardian stated she learned from HSW #1001 that the facility would not allow the resident to return. The guardian stated there were several back-and-forth conversations with the facility from 08/28/24 through 09/05/24 related to Resident #8601 returning, with the facility stating they were not taking him back, they did not have to take him back and they would not let him in. The guardian stated the communications came from the Administrator, DON and SW #106. The guardian stated she received the same response from the facility on 09/12/24 when the hospital again attempted to discharge the resident back to the facility, and he was refused readmission. The guardian stated even after the discharge appeal hearing on 09/05/24, which ordered the facility to readmit Resident #8601, the facility refused the resident's readmission from the hospital.</p> <p>A telephone interview on 09/19/24 at 9:10 A.M. with Licensed Practical Nurse (LPN) #425 revealed at the time Resident #8601 was sent to the hospital on 08/28/24, she was unaware the facility would not readmit the resident. During a meeting on 08/29/24, Regional Director of Operations (RDO) #500 decided Resident #8601 was being discharged immediately and would not return to the facility.</p> <p>A telephone interview on 09/20/24 at 2:12 P.M. with the Administrator confirmed on 08/28/24 at 8:34 P.M., text messages were exchanged between her, the DON, Registered Nurse (RN) #306, LPN #425 and HL #175 indicating Resident #8601 would not be readmitted to the facility. The Administrator confirmed RDO #500 made the decision not to readmit Resident #8601 and this decision was communicated to all department heads during the morning meeting on 08/29/24. Resident #8601 did not return to the facility, even after the discharge appeal hearing officer ordered the facility to readmit the resident from the hospital.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number OH00157356.</p>		