

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2021 Shoaf Dr Irving, TX 75061	

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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on interview and record review, the facility failed to develop and implement an effective discharge process that focuses on the resident's discharge goals and effectively transition them to post discharge care for 1 of 1 (Resident #1) resident reviewed for an effective discharge process.</p> <p>The facility failed to ensure Resident #1 was not discharged pending a discharge appeal.</p> <p>This failure could place residents who discharge at risk of improper discharge, unmet needs, and harm.</p> <p>The findings included:</p> <p>Record review of Resident #1's undated face sheet indicated Resident #1 was an a [AGE] year- old male admitted to the facility on [DATE] with diagnoses which included but not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region (develop from direct open spinal trauma, infections in surrounding areas and from bacteria that spreads to a vertebra from the blood), pressure ulcer(localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences).</p> <p>Review of the admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of Section Q participation in assessment and goal setting revealed plans to discharge to community.</p> <p>Review of Resident #1's care plan revised 4/2/2024 revealed Resident #1 required assistance with ADL's. The Care plan did not address discharge planning.</p> <p>Review of the facility provided Notice of Medicare non coverage for Resident #1 revealed Medicare skilled services would end on 4-8-2024. The Notice stated you have the right to an immediate independent medical review(appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.</p> <p>Interview on 04/17/2024 at 10:00 a.m., with Resident #1's family member revealed Resident #1 was discharged home even though an appeal was completed. The family member stated Resident #1 was discharged home without the results of the appeal and without home health services.</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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Social Worker 04/17/2024 at 12:35 PM, revealed Resident #1 was given a notice of discharge by human resources. She stated prior to discharge she tried to find a nursing home and set up DME for the resident. The Social worker stated she documented all her attempts to find a facility and DME for Resident #1 in the resident file. The Social worker stated she ran into issues because the resident's insurance was out of network. She stated the resident wanted to be discharged to [NAME], Texas however his insurance was out of network and DME could not be approved. The social worker stated she also reached out to the case manager from the insurance company to assist in finding a place for the resident. The Social Worker stated typically they would ensure a resident is discharged to a safe place. She stated Resident #1 was kept a week past his discharge date to try to find a safe place and ensure services were set up. The Social worker stated resident #1's family member was given the opportunity to keep the resident in the facility and pay for respite care however she declined. She stated Resident #1 did not have Medicare instead had a commercial insurance which was not widely accepted.</p> <p>Interview on 04/17/2024 at 12:45 PM, Human Resources revealed she had been standing in for the business officed manager since the facility did not have one employed. She stated Resident #1 was issued the notice of Medicare non- coverage by the MDS nurse on 04/05/2024. She stated Resident #1 did appeal the decision however she was not sure whether the appeal was approved. She stated Resident #1 did not have Medicaid and had a commercial insurance. She stated Resident #1 did not qualify for Medicare due to not having SSI. She stated the resident was informed that he would need to complete the SSI application in order to qualify for Medicare however it had not been done yet.</p> <p>Interview on 04/17/2024 at 1:05 PM, the Administrator revealed Resident #1 did not have Medicare however was given the notice of Medicare coverage to ensure Resident #1 was aware that coverage was ending. The Administrator stated typically if a resident appealed a discharge due to Medicare coverage ending then discharge before the appeal was complete would not occur. The Administrator stated Resident #1 had commercial insurance and that company did not send a letter to the facility with the determinations of the appeal. The Administrator stated the resident had already been allowed to stay 1 week past the last coverage date therefore the resident was discharged . The Administrator stated Resident #1's insurance no longer paid for the Resident #1's stay after 4/8/2024 however the facility did not discharge Resident #1 until 4/12/2024. The Administrator stated the facility exhausted all resources attempting to find another facility that would accept the resident however due to the insurance that Resident #1 had they were not able to secure placement. The Administrator stated Resident #1 was given the option to stay at the facility with respite care and pay out of pocket however refused to pay out of pocket. The Administrator stated she thought that since the resident had commercial insurance and not Medicare that he was able to be discharged prior to appeal decision. The facility provided policy regarding discharge and transfer did not discuss the appeal process.</p>		