Florida Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11040961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIATA AT SANTA BARBARA	216 SANTA BARBARA BLVD , CAPE CORAL, Florida, 33991

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	INITIAL COMMENTS An unannounced complaint survey for complaint number 2026005813, 2026005813, 2026003358, 2026003434, and 2026004181 was conducted from through at Aviata at Santa Barbara, a nursing home in Cape Coral, Florida. A Class I deficiency was identified at N201. Refer to Event ID 1F1F04-H2. Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that or serious physical or emotional harm would result therefrom. On at approximately 2:07 a.m., Resident #1 who had a full code status (Administer in the event of or) was found without or . The clinical staff consisting of one Registered Nurse and one Licensed Practical Nurse failed to provide appropriate basic life support to the resident. Clinical staff did not activate Emergency Medical Services ( ) and administered ( ) for about 20 minutes. The nurses discontinued and pronounced the resident's without the required credentials. Clinical staff re-started 4 hours later and called . Resident #1 was pronounced by . The facility failure to ensure staff to follow established policies and procedures, and provide timely, appropriate emergency care to Resident #1, including immediate activation of , created an imminent danger for all other 71 other residents with a full code status to not receive per their wishes and resulted in the Class I deficiency. On at 12:21 p.m., the facility Administrator was notified of the Class I deficiency. The facility census was 112. The following is a description of the deficiencies.	N0000		

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

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N0500 SS = D	Discharge/ Transfer Requirements CFR(s): 400.0255( ), FS; 59A-4.106(1)(f), FAC 400.0255 FS (1) As used in this section, the term: (a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care. (b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting. (2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident. 59A-4.106(1)(f) FAC (f) All resident transfers and discharges must be in accordance with the facility's policies and procedures, provisions of Sections 400.022 and 400.0255, F.S., this rule, and Title 42 Code of Federal Regulations section 483.12(a), revision date , , herein incorporated by reference and available at http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/xml/CFR-2014-title42-vol5-sec483-12.xml and http://www.flrules.org/Gateway/reference.asp?No=Ref-06375, and will include notices provided to residents by using Nursing Home Transfer and Discharge Notice, AHCA Form 3120-0002, , herein incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06017, "the Fair Hearing Request for Transfer or Discharge From a Nursing Home, AHCA Form 3120-0003, , , herein incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06018, the Long-Term Care Ombudsman Council Request for Review of Nursing Home Discharge and Transfer, AHCA Form 3120-0004, , , herein incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06019 or the Spanish language version, Solicitud de Revisión de Long-Term Care Ombudsman de la Dada de Alta o El Traslado de un Hogar de Ancianos, AHCA Form 3120-0004A, , , herein incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06020. These forms may also be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, Mail Stop #33,	N0500	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of these deficiencies cited are correctly applied. 1. The Identified resident's #2 discharge documentation was reviewed. Resident no longer resides in facility. 2. A 100% audit of all transfers/discharge forms and bed hold within the past 30 days was conducted to verify compliance with F627 requirements. Any discrepancies identified were immediately corrected, including issuance of proper notices and documentation updates. Residents under consideration for transfer/discharge will be reviewed to ensure full compliance with regulatory requirements. 3. A discharge checklist was developed to ensure all required steps are completed prior to any transfer or discharges. Education completed with all licensed nurses on discharge checklist and transfer/discharge forms and bed hold education. All planned discharges will be reviewed by IDT prior to discharge to ensure compliance. 4. Social Services Director or designee will conduct 4x/week audits of all transfers/discharges for 4 weeks, then 3x/week x 4 weeks; then, 2x/week x 4 weeks; then, weekly x 4 weeks to ensure regulatory compliance. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until committee determines substantial compliance has been met.	

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N0500 SS = D	Continued from page 2 Tallahassee, FL 32308 or at the web address http://ahca.myflorida.com/. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility's policies and procedures, resident representative and staff interviews, the facility failed to allow the return to the facility post hospitalization for 1 (Resident #2) of 7 residents reviewed for discharge planning process. The findings included: Review of the facility's policy and procedure titled, "Transfer/Discharge Notification & Right to Appeal" with a revision date of revealed, "Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge the resident unless: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the center; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the center; The safety of individuals in the center is endangered due to clinical or behavioral status of the resident; The health of individuals in the center would otherwise be endangered. . . Emergency transfers to Acute Care: Residents who are sent emergently to an acute care setting, must be permitted to return to the center. If the Center initiates a discharge while the resident is in the hospital, the center must show evidence that the resident's status at the time of the return to the center meets the criteria listed above (A-D) . . ." Review of the clinical record for Resident #2 revealed an admission date of . Diagnoses included , , Problem with Social Environment, Unspecified , , History of , , Mild , of unknown origin, due to known , Condition with Mixed Features, and Adjustment with Mixed , and Depressed .	N0500		

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N0500 SS = D	Continued from page 3 Review of the Minimum Data Set (MDS) Assessments revealed: The Quarterly MDS with an assessment reference date of revealed Resident #2 scored "15" of 15 on the (screening to assess cognition, specifically memory and orientation), indicating intact cognition. The MDS noted that Resident #2 did not exhibit physical or verbal behavioral symptoms directed toward others. The Discharge MDS assessment with an observation end date of revealed that on Resident #2 had an unplanned discharge-return . The MDS noted that Resident #2 did not exhibit physical behavioral symptoms directed toward others or verbal behavioral symptoms directed toward others. Review of Resident #2's care plan revealed: The resident wished to stay Long Term Care (LTC) at the facility (Date initiated). Resident #2 was verbally aggressive towards staff (Date initiated). Resident #2 had behaviors of yelling at other residents and telling them to "Shut your "(Date initiated). Review of the progress notes revealed: On the , Provider documented that Resident #2 has been , , , and responding to internal stimuli. He has a history of , , , and he has been presenting with bizarre and tangential behavior. He has refused all medications or staff care and assistance that could help redirect him. He is being aggressive, impulsive refusing medications and is a danger to self. Resident #2 has failed all interventions by staff to keep him safe. He requires a higher level of care to ensure his safety and the safety of others. The , Provider documented that Resident #2 required to be (involuntary, emergency examination). On at 5:29 p.m., the Director of Nursing (DON) documented in a late entry, "Resident had a burst of anger with uncontrolled behavior screaming, kicked the entrance door of his room and created a hole on the wall. He messed up his bed sheets as well, kicked the wall by his TV across from his bed TV, creating big hole, carrying on for approximately	N0500		

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N0500 SS = D	Continued from page 4 ½ hour, notified law enforcement . . . Psych Provider ordered to Backer Act. Law enforcement arrived followed by (Emergency Medical Services). order from (Provider) was presented to the law enforcement and . When law enforcement arrived, resident had calm [sic] down but from clinical standpoint, the inappropriate behavior presented by the resident and witnessed by me and several staff and other alert residents was frightening and resident needs to be out of the facility for staff and other residents' safety. Resident's mother arrived and was fully aware of his inappropriate behavior. Resident left the facility via stretcher w/ (with) and law enforcement approximately 6 PM." On at 3:52 p.m., the DON documented that Resident #2 was being admitted. She spoke with the case manager who will be available the next day to discuss discharge plan for the resident. The clinical record lacked documentation that a bed hold policy was offered to the resident or representative at the time of transfer to the hospital. Review of the hospital record revealed that Resident #2 was admitted on and discharged on . The hospital course synopsis documented that Resident #2 was admitted under involuntary commitment for evaluation of mental health concerns following reported aggression at his memory care facility. On admission, Resident #2 was calm, , , and oriented, with no evidence of acute distress or , , complaint. He denied or and was medically cleared in the Emergency Department. He was not accepted for , , facility placement due to wheelchair dependence and immobility. The , , evaluation, including a telemedicine consult determined that Resident #2 did not meet criteria for involuntary inpatient or outpatient , , placement. The orders and associated safety protocols were discontinued. He was cleared for discharge from a , , perspective with recommendations for intensive outpatient , rehabilitation and provision of outpatient mental health resource information. Case management and social work were involved in discharge planning, as his prior skilled nursing facility refused to accept him , and alternative placement options specializing in , , were discussed with his emergency contact. On at 11:00 a.m., in an interview, the DON	N0500		

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N0500 SS = D	Continued from page 5 verified that there was no documentation Resident #2 was offered a bed hold at the time of the transfer to the hospital. She said that Resident #2's emergency contact declined the bed hold. The DON also verified that when Resident #2 was ready to be discharged from the hospital, the facility refused to take him . She said that she thought Resident #2 would be better off in a group home due to his age and volatile behavior. On at 12:01 p.m., in a telephone interview, the emergency contact said since the facility refused to allow Resident #2 to come , he was placed in a nursing home located approximately 73 miles and 2-hour drive from her house. She said that Resident #2 at the new facility once in the middle of the night and called her screaming for help. It caused her much distress since she could not get to him. She ended up taking him home which has caused her to miss work and has caused emotional problems since she does not know how to manage his care. She said that Resident #2 was not doing well at home. He had done well at the facility for 7 months and she would like him to return there. The emergency contact said that Resident #2 was not available for an interview. On at 12:54 p.m., in an interview, the Admissions Director said that approximately 4 to 5 days after Resident #2 was transferred to the hospital under a , the hospital notified them that he was ready to return to the facility. She said that her regional leader told her not to accept the resident and that he was not to be accepted to any of their sister facilities. On at 12:57 p.m., in an interview, the Administrator said that a bed hold was not offered to Resident #2 and there was no documentation of the basis for discharge of the resident. She said the regional team decided to not allow Resident #2 to return to the facility, based on the information provided by facility staff. Class III	N0500		

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F0000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2026005813, 2026003358, 2026003434, and 2026004191was conducted from through at Aviata at Santa Barbara, a nursing home in Cape Coral, Florida. Aviata at Santa Barbara was not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities Immediate Jeopardy was identified at F678, and F726, at a scope and severity of J ( ) beginning on . Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements has caused, or is likely to cause serious injury, harm or to a resident requiring care in the facility. On at approximately 2:00 a.m., the facility failed to provide appropriate basic life support to Resident #1 with a Full Code status who was found without a , or , . Clinical staff did not activate Emergency Medical Services ( ) and administered , , ( ) for about 20 minutes. The nurse discontinued and pronounced the resident's without the required credentials. Clinical staff re-started 4 hours later and called . The facility failure to provide appropriate basic life support to full code residents in the event of or , , placed all 71 residents with a full code status at a likelihood of serious harm or and resulted in the determination of immediate jeopardy. On at 12:21 p.m., the Administrator was notified of the determination of Immediate Jeopardy (IJ) and provided the IJ templates. Substandard Quality of Care was identified at: §483.24(a)(3) Personnel provide basic life support, including , to a resident requiring such	F0000		

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 reverse for further 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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F0000	Continued from page 1 emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. (F678). A partial extended survey was completed on . The Immediate Jeopardy was removed, effective , after review and verification of immediate actions implemented by the facility. The facility census was 112. The following is a description of the noncompliance.	F0000		
F0678 SS = SQC-J	- , ( ) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including , to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility's policy and procedure and staff interviews, the facility failed to provide immediate and appropriate basic life support to 1 (Resident #1) of 3 residents reviewed with full code status (Administer ' ' in the event of or , ' '). On at approximately 2:07 a.m., the clinical staff consisting of one Registered Nurse (RN) and one Licensed Practical Nurse (LPN) administered ( ) to Resident #1 when he was found without a , or , . The Licensed Nurses did not activate Emergency Medical Services ( ) and discontinued after approximately 20 minutes. The RN pronounced the resident's without the required credentials. Clinical staff re-started 4 hours later at the direction of the Director of Nursing and called . Resident #1 was pronounced by . The facility failure to immediately activate and administer to Resident #1 until the arrival of placed other residents with full code status at a likelihood of serious injury or from not receiving appropriate lifesaving interventions in the event of and/or , . This failure resulted in the determination of Immediate Jeopardy (IJ).	F0678	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of these deficiencies cited are correctly applied. Resident #1 no longer resides in the facility as of 4.7.26. This has the potential to affect all residents in the facility. All codes to 1.1.26 were reviewed to ensure protocol was followed. No outliers were noted. All licensed nurses received education from the Director of Nursing and/or nursing management on policy and procedure and Florida policy. This includes where to find the code status. Education addressed what to do for full code hospice residents. Education completed with CNA's that protocol is that they do not assist with , or breaths during a event. All education will be added to new hire orientation. Code drills will occur 3 x weekly x 4 weeks, followed by 2 x weekly x 4 weeks, followed by 1 x weekly x 4 weeks. Results will be brought to QAPI to determine need for ongoing auditing.	

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F0678 SS = SQC-J	Continued from page 2 On , after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed, effective . The scope and severity were reduced to "D", no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross Reference F726 Review of the facility's policy and procedure titled, "Florida , ( )" with a revision date of revealed, " { } will be provided to all residents who are identified to be in unless such resident has a fully executed Florida ( ) order. . . In the event of , immediately call for assistance . . . Use the page system and call "Code Blue" to Room Number or location of the event three times. In the absence of a fully executed Florida . . . the facility will immediately begin . Center staff will continue performing until Emergency Medical Technicians assume responsibility for , or it may be discontinued if the resident responds . . ." Review of the clinical record for Resident #1 revealed an admission date of . Diagnoses included , (a slow-progressing circulation involving the narrowing, blockage, or spasms of), (a condition that restricts airflow and makes breathing difficult), and 's . The physician's order dated specified "Full Code" status. The care plan initiated on noted that Resident #1had, "Incapacity and Guardianship by Court Order honoring his wishes Full Code". On at 2:07 a.m., RN Staff A wrote in a nursing progress note, "CNA (Certified Nursing Assistant) called me. She found the resident unresponsive in his bed at 2:07 am. Assessment: Absence of , / , . Pupils do not respond. DON (Director of Nursing), Guardian and Provider was [sic] notified". On at 6:00 a.m., the DON wrote in a progress note, "Received a message from assigned Nurse that resident has no , . , no , , no	F0678		

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F0678 SS = SQC-J	Continued from page 3 pressure. It was reported that a CNA found the resident, assigned nurse-initiated , was notified, arrived at facility, continue , unable to revive resident. pronounced resident expired at 6:31 AM with Diagnosis: Sudden . . ." Review of the Patient Care Record dated revealed was activated on at 6:18 a.m., arrived at the facility at 6:27 a.m., and pronounced Resident #1's at 6:31 a.m. The report noted that the patient's jaw was locked and non-moveable. The patient's extremities were stiff and unmovable. The narrative noted that on arrival, facility staff was doing active . was "not attempted-Considered Futile." The first impression was " (postmortem stiffening of the), Algor Mortis (postmortem cooling of the body), Apneic (cessation of breathing), Pulseless and Unresponsiveness". documentation noted "facility staff on scene stated the last time they saw the , (patient) was 11pm last night". On at 9:44 a.m., in an interview, the Administrator said that they investigated the incident and concluded that on at 2:00 a.m., 911 was not called when Resident #1 was found unresponsive. Review of the facility provided investigation revealed: On , Certified Nursing Assistant (CNA) Staff C wrote in a witness statement that on at 2:00 a.m., she found Resident #1 unresponsive and immediately notified RN Staff A. RN Staff A said that she already knew that the resident was going to die and instructed her to clean the resident. Another CNA helped her clean and cover Resident #1. On RN Staff A documented in a witness statement that on around 2:00 a.m., one of the caregivers told her that she thought Resident #1 was . She ran to the door, called LPN Staff B and said, "Hey Code Blue". LPN Staff B brought the crash cart and they started . RN Staff A said they administered to Resident #1 for approximately 20 minutes. She told LPN Staff B that the resident had no vital signs (, , , , ,) but he was warm and not responding at all. She thought Resident #1 was in hospice and that was the reason why she did not call 911. On at approximately 5:50 a.m., the DON called and asked her if she had called 911. She then immediately called 911. They arrived at 6:00 a.m. and took control of the situation.	F0678		

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F0678 SS = SQC-J	Continued from page 4 On , LPN Staff B wrote in a witness statement that a Certified Nursing Assistant (CNA) notified RN Staff A that Resident #1 was unresponsive. RN Staff A checked her report sheet and called a code blue. He took the crash cart to the room, and they administered to the resident. After about 20 minutes, RN Staff A called it off and said something about, "He was gone or words to that effect". RN Staff A then started calling people. On , CNA Staff D wrote in a witness statement that she came in to work early on . RN Staff A asked her to put the board under Resident #1 (Firm board to ensure effective during) and do . She was doing when arrived. One minute later, told her to stop the . She left the room. On at 10:39 a.m., in a telephone interview, CNA Staff D said that on at around 6:00 a.m., RN Staff A asked her to place the board under Resident #1 and do until arrives. She had done 5 or 6 when arrived. She continued the until told her to stop. On at 11:20 a.m., in a telephone interview, RN Staff A said that on she was the nurse in charge for the night shift. At approximately 2:00 a.m., CNA Staff C told her that she thought Resident #1 had . She yelled "Code Blue" and yelled for help. LPN Staff B brought the crash cart, and they administered to the resident. After 3 to 5 rounds of , she told LPN Staff B that Resident #1 was not there anymore. She said, "I don't pronounce anyone , but he was without vital signs". She called the CNAs and they cleaned him up. RN Staff A verified she did not call 911 and discontinued . RN Staff A said, "This is not my normal resident. I thought he was hospice, so I did not call 911." She notified the DON, the Provider and Resident #1's family members. She said at approximately 5:50 a.m., the DON called the facility and asked if she had called 911. She told the DON that she had not called 911 since she was by herself with the CNA and LPN Staff B. RN Staff A said she told the DON that she was about who was on hospice and who was a full code. RN Staff A said, "I don't pronounce them , but I knew he was , no vitals, no , . Nurses don't pronounce residents . We found him , we know he is because it is clinical". RN Staff A said the DON instructed her to call 911. She said she reinitiated at 6:00 a.m. after calling 911. RN	F0678		

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F0678 SS = SQC-J	Continued from page 5 Staff A said, "We tried to do something until came because they have to see us doing . They repronounced him after that". RN Staff A verified that she reinitiated approximately 4 hours after Resident #1 had no , or , and was stopped. On at 1:22 p.m., in an interview, the DON said that on at 2:42 a.m., RN Staff A sent her a text message letting her know that Resident #1 had expired. She called the facility at approximately 6:00 a.m., and instructed RN Staff A to call 911. She did not know why RN Staff A reinitiated . She verified that the facility's investigation determined that RN Staff A and LPN Staff B did not follow the facility's established policy and procedure to call 911 and administer to Resident #1 until the arrival of . On at 8:48 a.m., in a telephone interview, CNA Staff C said that on at around 2:00 a.m., she found Resident #1 unresponsive and immediately notified RN Staff A. CNA Staff C said that RN Staff A came to the resident's room, took vital signs then instructed her to clean the resident. On at 3:11 p.m., in a telephone interview, the Medical Director said that Resident #1 was a full code. They should have started and called 911. He said that should not be done 4 hours after a resident is pronounced On , the survey team verified through review of the certification for all licensed nurses currently employed at the facility. Starting on , the Director of Nursing and/or nursing management educated licensed nurses on policy and procedure and Florida ( ) policy. This included where to find the code status. Education also addressed what to do for scenario with full code hospice residents. Education was completed on initiating services immediately when a resident is full code. Education included that is to continue on a full code resident until arrives and that the nurse cannot pronounce on the full code resident and/or stop until instructed by . 32/32 licensed nurses have been educated. On , the survey team verified through review of the education provided and interview with 3 licensed nurses and 2 CNAs. On , 3 additional licensed nurses interviewed verified receipt and content of the education.	F0678		

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F0678 SS = SQC-J	Continued from page 6 Starting immediately on , Nursing Management conducted Emergency response code blue drills were conducted daily on all three shifts. Drills are ongoing daily on all three shifts with compliance noted. Drills included full code, and Full code hospice scenarios. Full code drills included emphasis on calling immediately. 30/32 licensed nurses have participated. The remaining 2 licensed nurses are PRN (as needed) and have not worked since . They will participate prior to their next working shift. CNA's have participated. On , the survey team verified through review of the content of the daily emergency response code blue drills on all 3 shifts. On , 3 licensed nurses and 2 CNAs were interviewed and verified participation in code blue drills and verified content of the emergency response for full code residents. On , interview with 3 additional licensed nurses verified participation in code blue drills and emergency response when a resident is found in and/or , , . Starting on , the Administrator and/or Nursing Management educated the licensed nurses and CNAs regarding the facility and neglect policy, including resident rights. 32/32 licensed nurses have been educated. CNAs have been educated. On , the survey team verified through review of the documentation of the education provided and interview with 3 licensed nurses and 2 CNAs. Starting on licensed nurses received and completed a post-test. 30/32 licensed nurses have completed a post-test with 100% accuracy. The remaining 2 licensed nurses are prn and will complete the test prior to their next working shift. On , the survey team verified through record review that 30 licensed nurses completed the post-tests. On , interview with 3 licensed nurses verified that they received the training and completed the post-test. On at 2:52 p.m., in an interview, the Administrator said that the 2 employees who have not completed their training will not be allowed to work until they complete the education. Starting on , the Director of Nursing and/or nursing management educated licensed nurses regarding change in condition. 30/32 licensed nurses have received the education. The remaining 2 licensed nurses are PRN will complete the test prior	F0678		

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F0678 SS = SQC-J	Continued from page 7 to their next working shift. On , the survey team verified through review of the education provided regarding change in condition and interview with 3 licensed nurses. Starting on the Administrator placed laminated instructions on how to overhead page during a code for all four nursing station phones, the activity office phone, and the , , gym phones. On at 2:29 p.m., the survey team verified through observation that all 4 nurse's stations, the activity's office and the , , gym's phone had laminated instructions on how to overhead page during a code. On an ADHOC (unplanned) Quality Improvement Performance Committee meeting was held to review the recommendations made from the root cause analysis. The root cause analysis showed that the nurse believed the resident was hospice and did not start or call when the resident was found without and . The root cause of this was that she did not check the code status as outlined in the facility policy. All recommendations were approved by the committee. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS (Minimum Data Set), Unit Manager, Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director. On , the survey team verified through record review and interview with the Administrator that a Quality Improvement Performance Committee meeting was held on and discussed the root cause of the incident and the recommendations were approved by the committee. The root cause documented was," staff knowledge on when can be discontinued and when 911 is called. Nurse did not check code status. Policy not followed". The survey team verified participation of team members listed on the facility's removal plan. On , a follow-up Ad HOC Quality Improvement Performance Committee meeting was held to review plan progress. All recommendations were approved by the committee. The following team members were in attendance: Medical Director, Executive Director, Regional Director of Clinical	F0678		

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F0678 SS = SQC-J	Continued from page 8 Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS (2), DON traveler, Unit Managers (2), Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director. On , the survey team verified that on the facility held a Quality Improvement Performance Committee meeting and reviewed the plan's progress. The survey team verified participation of team members listed on the facility's removal plan. On , the Regional Nurse Consultant completed a like resident audit. All expired residents and re-hospitalizations from through were reviewed to see if involved staff were the same as code event and if proper procedure was followed. Staff identified in incident were not involved in previous codes or re-hospitalizations. All codes were handled per policy. On , the survey team verified through record review and interview with the Administrator and DON that, on the Regional Nurse Consultant completed an audit of all expired and re-hospitalized residents from through to ensure proper procedure was followed and all codes were handled per facility's policy. Staff identified in the incident involving Resident #1 were not involved in previous codes or re-hospitalization. Review of the clinical records for 2 residents listed on the audit revealed no concern. One resident coded at the facility and staff acted appropriately. One resident was appropriately transferred to the hospital and coded at the hospital.	F0678		
F0726 SS = J	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and , well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F0726	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of these deficiencies cited are correctly applied Resident # 1 no longer resides in the facility as of 4.7.26.	

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F0726 SS = J	Continued from page 9 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policies and procedures, and staff interviews, the facility failed to ensure clinical staff had the competencies to respond appropriately to emergencies and ensure 1 (Resident #1) of 3 residents reviewed with full code status (Administer , , in the event of or ,) received timely life saving measures when found without , or , . Resident #1 had a full code status. On , Resident #1 was found in and , . Clinical staff administered , , , ( ) for 20 minutes then pronounced the resident's without authority to do so and without activating Emergency Medical Services ( ). Clinical Staff re-started and activated 4 hours after was stopped and the resident had no , and , . The facility failure to ensure nursing staff were trained and competent to respond appropriately to and , placed other residents with full code status at risk of significant delay in receiving lifesaving emergency treatment when found without , or , and resulted in the determination of Immediate Jeopardy. On , after verification of an acceptable Immediate Jeopardy removal plan, the Immediate	F0726	Continued from page 9 This has the potential to affect all residents in the facility. All licensed nurses were audited to ensure current certification. Facility will ensure certification through a provider whose training includes a -on session either in a physical or virtual instructor-led setting in accordance with accepted national standards. Human resources, or designee, will audit monthly to ensure all licensed nurses have a current certification. Education was completed with licensed nurses on initiating services immediately when a resident is full code. Education included that is to continue on a full code resident until arrives and that the nurse cannot pronounce on the full code resident and/or stop until instructed by . Education will be added to new hire orientation. 7 random licensed nurses will complete a knowledge quiz related to code events. Per week x 4 weeks, followed by 5 nurses x 4 weeks, then 3 nurses x 4 weeks. Results will be brought to QAPI to determine need for ongoing auditing.	

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F0726 SS = J	Continued from page 10 Jeopardy was removed, effective . The scope and severity were reduced to "D", no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross reference F678. Review of the "Facility Assessment Tool" updated revealed, "List all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and how often they are reviewed after that. Consider the following training topics . . . Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention . . . Consider the following competencies . . . Person-centered care . . .person-centered care planning . . . end-of-life care, and advance care planning . . ." Review of the facility's policy and procedure titled, "Florida ( )" with a revision date of revealed, " , , ( ) will be provided to all residents who are identified to be in unless such resident has a fully executed Florida ( ) order. Procedure. In the event of , immediately call for assistance . . . In the absence of a fully executed Florida . . . , the facility will immediately begin . Center staff will continue performing until Emergency Medical Technicians assume responsibility for , or it may be discontinued if: The resident responds. . ." Review of the facility provided incident investigations revealed that on at approximately 2:07 a.m., clinical staff consisting of Registered Nurse (RN) Staff A and Licensed Practical Nurse (LPN) Staff B failed to respond appropriately when Resident #1 with a full code status was found without a , or , , . The nurses did not activate and discontinued after 20 minutes. RN Staff A pronounced the resident's without authority to do so. RN Staff A restarted , four hours after she pronounced the resident's , and activated Emergency Medical Services ( ) per the Director of Nursing's instruction. pronounced the resident's on at	F0726		

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F0726 SS = J	Continued from page 11 6:31 a.m. Review of the Facility provided meeting minutes dated revealed that the root cause of the incident was, "Staff knowledge on when can be discontinued and when 911 is called. Nurse did not check code status." On at 10:39 a.m., in an interview, CNA Staff D said that on at approximately 6:00 a.m., RN Staff A instructed her to put the board (Stiff board to ensure effective ,) under Resident #1 and asked her to administer , to the resident. She did roughly 5 or 6 , before arrived. She continued the , until told her to stop. On at 11:20 a.m., in a telephone interview, RN Staff A said that on at 2:07 a.m., she did not activate when Resident #1 with a full code status was found without a , or . , . She asked LPN Staff B for help. They administered for 20 minutes then stopped. RN Staff A said that nurses do not pronounce residents and said, "I knew he was , no vitals, no , . We found him , we know he is because it is clinical". She said that she was on who was hospice and who was a full code. She said, "I thought he was hospice, so I did not call 911". RN Staff A said that on at approximately 6:00 a.m., 4 hours after was stopped, the Director of Nursing (DON) called the facility and instructed her to call . RN Staff A said, "We tried to do something until came because they have to see us doing . They [ ] repronounced him [Resident #1] after that". On at 11:38 a.m., in a telephone interview, LPN Staff B verified that on at approximately 2:07 a.m., RN Staff A asked for his help when Resident #1 was found unresponsive. He said, "I thought she had called 911. We did for about 20 minutes, and she [RN Staff A] called the code. I did not call 911 because I was doing . " He said that RN Staff A told him, "Oh, we are not going to bring him ", so she called the code (stopped) and left. He said that RN Staff A was the charge nurse but he should have spoken up since he knew to continue until the arrival of . The Director of Nursing called the facility at approximately 6:00 a.m. and instructed RN Staff A to activate . They called 911 and restarted at that time. He said that RN Staff A did not say why they restarted , "no one said anything. It was strange."	F0726		

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F0726 SS = J	Continued from page 12 Review of RN Staff A's employee file revealed a date of hire of . RN Staff A's job description titled, "Clinical Nurse I (RN)", dated revealed the job function included, "Responsible for providing direct resident care in accordance with established plans . . . Duties and Responsibilities . . . Assist nursing personnel to act in compliance with corporate policies, procedures and regulatory requirements. . .Provide routine nursing services for residents as directed . . . Education & Certification . . . Must have Certifications . . . Specific Requirements . . . Must possess the ability to make independent decisions when circumstances warrant such action . . ." RN Staff A did not sign the job description to acknowledge that she had read the job description and agreed to perform the tasks outlined in the job description in a safe manner and in accordance with the facility's established policies and procedures. Review of RN Staff A's BLS (Basic Life Support)/ Certification revealed a completion date of . The certification did not document a -on session either in a physical or virtual instructor-led setting in accordance with accepted national standards. On at 12:33 p.m., in a telephone interview, a representative of the BLS/ provider company where RN Staff A completed her BLS/ certification said that the BLS/ certification was fully online, was not led by an instructor and had no live feedback. Review of the facility's "Skills Competency Assessments for New Hires" revealed, "Evaluating and documenting competency of staff is required upon hire, annually and as otherwise indicated. . . Completed Skills Competency Assessment should be retained in employee personnel file . . ." RN Staff A's personnel file did not include a Skills Competency Assessment. Review of LPN Staff B's "Clinical Nurse I (LPN)" job description signed and dated with a date of hire of revealed, "Duties and Responsibilities . . . Act in compliance with the company, regulatory and professional standards and guidelines . . . Education & Certifications . . . Must have Certifications . . . Specific Requirements . . . Must demonstrate knowledge and skills necessary	F0726		

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F0726 SS = J	Continued from page 13 to provide care appropriate to the age-related needs of the residents served . . . Must possess the ability to make independent decisions when circumstances warrant such action . . . Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities. . ." Review of LPN Staff B's BLS/ certification dated revealed that it was valid for 2 years. Review of CNA Staff D's personnel file revealed a "Certified Nursing Assistant /State Tested Nursing Assistant" job description signed and dated with a date of hire of . The job description did not include BLS/ certification as an education requirement. CNA Staff D's personnel file included a BLS/ certification with an issue date of and specified to renew by . On at 1:22 p.m., in an interview, the Assistant Director of Nursing (ADON) verified that LPN Staff B's BLS/ certification dated was valid for 2 years, therefore was expired. The ADON also verified that CNA Staff D's BLS/ certification specified a renew date of and was expired. He said that per facility policy, CNAs were not allowed to do , including , and that nurses were expected to renew their certifications. The Human Resources department was responsible to review the nurses certifications upon hire and annually and notify the nurses 90 days before their certification expired. On at 12:04 p.m., in an interview, the Assistant Director of Nursing (ADON) said since he started employment at the facility in , they have been conducting monthly "Code Blue (/ , ,) Drills." He said that RN Staff A went from working the night shift to working the day shift and went to the night shift. RN Staff A then became the facility's weekend supervisor but had not participated in any Code Blue drill. Review of the facility provided monthly code blue drills for , , , , and , failed to reveal documentation of RN Staff A's participation. On at 10:28 a.m., in an interview, the Nursing Home Administrator said that RN Staff A received no orientation or skills competency	F0726		

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F0726 SS = J	Continued from page 14 evaluation since her hire date of and was promoted to the weekend supervisor's position on . On at 10:30 a.m., in an interview, the Human Resources Director, and the Director of Training verified that RN Staff A had no onboarding education, no orientation and no nursing competency evaluations on file. On at 10:38 a.m., an interview was held with the DON and the ADON. The DON said that newly employed licensed nurses are expected to have 3 days of clinical orientation and complete skills competency evaluations. The licensed nurses must meet expectations. She said, "No one should be working on the floor without completing orientation and skills competencies." The ADON said that the Administrator, DON and Human Resources were responsible to ensure staff completed orientation and skills competencies. He said that RN Staff A failed all the tests for the Clinical Manager's position and should not have been a Unit Manager. He said that RN Staff A, "cut corners and got away with it." On at 11:31 a.m., in an interview, the Administrator said that each department had a part in the onboarding process of new employees. She said that there was also a clinical orientation. She confirmed that there were no records that RN Staff A completed orientation or skills competencies before being promoted to the weekend supervisor's position. On , the immediate actions implemented by the facility and verified by the survey team included: On , , , the Regional Director of Clinical Services verbally educated the Administrator and Director of Nursing regarding the policy and need to immediately contact services in the event of a full code. The administrator and DON signed the education on , , . On , the survey team verified documentation dated , that the Regional Director of Clinical Services educated the Administrator and Director of Nursing regarding the policy and need to immediately contact services in the event of a full code. Starting on , , , the Director of Nursing and/or nursing management educated licensed nurses on policy and procedure. This included	F0726		

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F0726 SS = J	Continued from page 15 where to find the code status. Education also addressed what to do for scenario with full code hospice residents. Education was completed on initiating services immediately when a resident is full code. Education included that is to continue on a full code resident until arrives and that the nurse cannot pronounce on the full code resident and/or stop until instructed by . 32/32 licensed nurses have been educated. On , the survey team reviewed the content of the education and verified that 32 of 32 licensed nurses were educated. On , 3 licensed nurses and 2 CNAs verified receipt and content of the education related to policy and procedure. On , 3 additional licensed nurses were interviewed. Each licensed nurse verified receipt of the education and verbalized content of the education related to the facility's policy and procedure. On , , an Ad HOC (unplanned) Quality Improvement Performance Committee meeting was held to review the recommendations made from the root cause analysis. The root cause analysis showed that the nurse believed the resident was hospice and did not start or call when the resident was found without , and . The root cause of this was that she did not check the code status as outlined in the facility policy. All recommendations were approved by the committee. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS (Minimum Data Set), Unit Manager, Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director. On , the survey team verified through record review and interview with the Administrator and DON that on a Quality Performance Meeting was conducted and the root cause of the incident discussed. The survey team verified participation of the Medical Director and department heads. On , , a follow-up Ad HOC Quality Improvement Performance Committee meeting was held to review plan progress. All recommendations were approved by the committee. The following team members were in attendance: Medical Director, Executive Director, Regional Director of Clinical Services (via telephone), Director of Nursing, Assistant Director of Nursing, Social Services, MDS	F0726		

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F0726 SS = J	Continued from page 16 (2), DON traveler, Unit Managers (2), Business development Coordinator, Director of Patient Experience, Business Office Manager, Maintenance Director, Nutrition Director, Housekeeping Director, and Activities Director. On , the survey team verified through record review and interview with the Administrator, and DON that on a follow up Quality Improvement Performance Committee meeting was held to review the plan's progress. The survey team verified participation of the Medical Director and department heads.	F0726		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate.	F0627	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of these deficiencies cited are correctly applied. 1. The Identified resident's #2 discharge documentation was reviewed. Resident no longer resides in facility. 2. A 100% audit of all transfers/discharge forms and bed hold within the past 30 days was conducted to verify compliance with F627 requirements. Any discrepancies identified were immediately corrected, including issuance of proper notices and documentation updates. Residents under consideration for transfer/discharge will be reviewed to ensure full compliance with regulatory requirements. 3. A discharge checklist was developed to ensure all required steps are completed prior to any transfer or discharges. Education completed with all licensed nurses on discharge checklist and transfer/discharge forms and bed hold education. All planned discharges will be reviewed by IDT prior to discharge to ensure compliance. 4. Social Services Director or designee will conduct 4x/week audits of all transfers/discharges for 4	

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F0627 SS = D	Continued from page 17 §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0627	Continued from page 17 weeks, then 3x/week x 4 weeks; then, 2x/week x 4 weeks; then, weekly x 4 weeks to ensure regulatory compliance. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until committee determines substantial compliance has been met.	

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F0627 SS = D	Continued from page 18 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the , location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the	F0627		

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F0627 SS = D	Continued from page 19 discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. ( ) Consider 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. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the	F0627		

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F0627 SS = D	Continued from page 20 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility discharge, a resident must have a discharge summary that includes, but is not limited to, the following: ( ) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility's policies and procedures, resident representative and staff interviews, the facility failed to allow the return to the facility post hospitalization for 1 (Resident #2) of 7 residents reviewed for discharge planning process. Resident #2 was discharged to a different nursing home approximately 73 miles from his family. The findings included: Review of the facility's policy and procedure titled, "Transfer/Discharge Notification & Right to Appeal" with a revision date of revealed, "Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. The center must permit each resident to remain in the center, and not transfer or discharge the resident unless: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the center; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the center;	F0627		

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F0627 SS = D	Continued from page 21 The safety of individuals in the center is endangered due to clinical or behavioral status of the resident; The health of individuals in the center would otherwise be endangered. . . Emergency transfers to Acute Care: Residents who are sent emergently to an acute care setting, must be permitted to return to the center. If the Center initiates a discharge while the resident is in the hospital, the center must show evidence that the resident's status at the time of the return to the center meets the criteria listed above (A-D) . . ." Review of the clinical record for Resident #2 revealed an admission date of . Diagnoses included , Problem with Social Environment, Unspecified , History of , Mild , of unknown origin, due to known Condition with Mixed Features, and Adjustment with Mixed , and Depressed . Review of the Minimum Data Set (MDS) Assessments revealed: The Quarterly MDS with an assessment reference date of revealed Resident #2 scored "15" of 15 on the (screening to assess cognition, specifically memory and orientation), indicating intact cognition. The MDS noted that Resident #2 did not exhibit physical or verbal behavioral symptoms directed toward others. The Discharge MDS assessment with an observation end date of revealed that on Resident #2 had an unplanned discharge-return . The MDS noted that Resident #2 did not exhibit physical behavioral symptoms directed toward others or verbal behavioral symptoms directed toward others. Review of Resident #2's care plan revealed: The resident wished to stay Long Term Care (LTC) at the facility (Date initiated). Resident #2 was verbally aggressive towards staff (Date initiated). The goal was for the resident to demonstrate effective coping skills. Resident #2 had behaviors of yelling at other residents and telling them to "Shut your " (Date initiated). The goal was for the resident to have fewer episodes of the behavior.	F0627		

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F0627 SS = D	Continued from page 22 Review of the progress notes revealed: On the , Provider documented that Resident #2 has been , , and responding to internal stimuli. He has a history of , , , and he has been presenting with bizarre and tangential behavior. He has refused all medications or staff care and assistance that could help redirect him. He is being aggressive, impulsive refusing medications and is a danger to self. Resident #2 has failed all interventions by staff to keep him safe. He requires a higher level of care to ensure his safety and the safety of others. The , Provider documented that Resident #2 required to be (involuntary, emergency examination). On at 5:29 p.m., the Director of Nursing (DON) documented in a late entry, "Resident had a burst of anger with uncontrolled behavior screaming, kicked the entrance door of his room and created a hole on the wall. He messed up his bed sheets as well, kicked the wall by his TV across from his bed TV, creating big hole, carrying on for approximately ½ hour, notified law enforcement . . . Psych Provider ordered to Backer Act. Law enforcement arrived followed by (Emergency Medical Services). order from (, Provider) was presented to the law enforcement and . When law enforcement arrived, resident had calm [sic] down but from clinical standpoint, the inappropriate behavior presented by the resident and witnessed by me and several staff and other alert residents was frightening and resident needs to be out of the facility for staff and other residents' safety. Resident's mother arrived and was fully aware of his inappropriate behavior. Resident left the facility via stretcher w/ (with) and law enforcement approximately 6 PM." On at 3:52 p.m., the DON documented that Resident #2 was being admitted. She spoke with the case manager who will be available the next day to discuss discharge plan for the resident. The clinical record lacked documentation that a bed hold policy was offered to the resident or representative at the time of transfer to the hospital. Review of the hospital record revealed that Resident #2 was admitted on and discharged on . The hospital course synopsis documented that Resident #2 was admitted under involuntary commitment for evaluation of mental health concerns following reported aggression at his memory care	F0627		

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F0627 SS = D	Continued from page 23 facility. On admission, Resident #2 was calm, , , and oriented, with no evidence of acute distress or , complaint. He denied or and was medically cleared in the Emergency Department. He was not accepted for , facility placement due to wheelchair dependence and immobility. The , evaluation, including a telemedicine consult determined that Resident #2 did not meet criteria for involuntary inpatient or outpatient , placement. The orders and associated safety protocols were discontinued. He was cleared for discharge from a , perspective with recommendations for intensive outpatient , rehabilitation and provision of outpatient mental health resource information. Case management and social work were involved in discharge planning, as his prior skilled nursing facility refused to accept him , and alternative placement options specializing in , were discussed with his emergency contact. On at 11:00 a.m., in an interview, the DON verified that there was no documentation Resident #2 was offered a bed hold at the time of the transfer to the hospital. She said that Resident #2's emergency contact declined the bed hold. The DON said that when Resident #2 was ready to be discharged from the hospital, the facility refused to take him . She thought that Resident #2 would be better off in a group home due to his age and volatile behavior. On at 12:01 p.m., in a telephone interview, the emergency contact said since the facility refused to allow Resident #2 to come , he was placed in a nursing home located approximately 73 miles and 2-hour drive from her house. She said that Resident #2 at the new facility once in the middle of the night and called her screaming for help. It caused her much distress since she could not get to him. The emergency contact said that Resident #2 was not available for an interview, but she would like for him to return to the facility. On at 12:54 p.m., in an interview, the Admissions Director said that approximately 4 to 5 days after Resident #2 was transferred to the hospital under a , the hospital notified them that he was ready to return to the facility. She said that her regional leader told her not to accept the resident and that he was not to be accepted to any of their sister facilities.	F0627		

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F0627 SS = D	Continued from page 24 On at 12:57 p.m., in an interview, the Administrator said that a bed hold was not offered to Resident #2 and there was no documentation of the basis for discharge of the resident. She said the regional team decided to not allow Resident #2 to return to the facility, based on the information provided by facility staff.	F0627		