N 531-SS=D

1200-8-6-05(14) Admissions, Discharges, and Transfers

(14) When the attending physician has ordered a resident transferred or discharged, but the resident or a representative of the resident opposes the action, the nursing home shall counsel with the resident, the next of kin, sponsor and representative, if any, in an attempt to resolve the dispute and shall not transfer the resident until such counseling has been provided. No involuntary transfer or discharge shall be made until the nursing home has first informed the department and the area long-term care ombudsman. Unless a disaster occurs on the premises or the attending physician orders the transfer as a medical emergency (due to the resident’s immediate need for a higher level of care) no involuntary transfer or discharge shall be made until five (5) business days after these agencies have been notified, unless they each earlier declare that they have no intention of intervening.

This Rule is not met as evidenced by:
Based on facility medical record review, Resident Census and Conditions of Residents Form review, hospital medical record review, and interviews the facility failed to readmit a resident that had been discharged from the facility to the hospital and failed to provide a thirty day discharge notice before discharging the resident for one (Resident #1) of four discharged residents charts reviewed.

Medical record review revealed Resident #1 was admitted to the facility on May 29, 2012 with diagnoses that included Dementia, Pleural Effusion, Emphysema, Hyponatremia, Leukocytosis, Anemia, Hypertension, Depression, Preparing and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

N531 The facility will ensure that discharged residents, whose clinical and behavioral needs can be safely met, will be readmitted according to state guidelines and company policy. In addition, facility will ensure proper 30-day notification will be provided and documented for all residents whose discharge would merit such, per state guidelines and company policy.

1) Resident #1 is no longer in the facility. Communication transpired between resident family, and facility administrator, social worker, and business office director on October 15, 2012, at the request of the family, ending with understanding, resolution, and satisfaction regarding previous discharge concerns.

Completion Date 11/27/12
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Pneumonia and Gastro-Esophageal Reflux.

Medical record review of an assessment dated June 8, 2012 revealed Resident #1 scored 6 of 15 (Cognitively Severely Impaired) on the Brief Interview for mental Status (BIMS). The assessment also revealed the resident had feelings of depression but had no signs and symptoms of Delirium, no presence of behavior symptoms, could understand others and could make self understood. The assessment further revealed the resident required extensive assistance for ambulation with a walker and required one person assist with dressing, hygiene and toilet use.

Medical record review of an Admission Nurses Note dated May 29, 2012 documented "Pt (patient) is confused but cooperative." A Nurses Note dated June 2, 2012 documented "Resident continue to get out of bed throughout the night. Pt. redirected (symbol for without) success." A Nurses Note dated June 19, 2012 at 0330 (3:30 am) documented "Assisted to bathroom 12 times since 2300 (11:00 pm)." A Nurses Note dated June 26, 2012 at 6:00 am documented "Calling out for constant attention "Please come talk to me." Other Nurses Notes reviewed from May 29, 2012 to August 22, 2012 documented Resident #1 was confused, yelling for help and attempting to get up without assistance

Review of a Progress Note-Psychotherapy dated August 22, 2012 at 10:50 am documented "Staff wanting to transfer to inpt (In patient) reporting (Resident #1) so pt can receive tx (treatment). Pt responding to internal stimuli. Yelling out for no reason. Hallucinations pres (present). Insight (symbol for and) judgment poor. Pt anxious (symbol for and) agitated, difficult to soothe."

2) All discharged resident charts from July 2012 through August 2012 were audited in October 2012 for compliance with 1200-8-6-.05(14) Admissions, Discharges, and Transfers. No incidents of concern pertaining to regulation and company policy were identified.

3) The facility management team, including, but not limited to the admissions coordinator, business office director, social worker/discharge planner, director of nursing, and assistant director of nursing were in serviced by the administrator regarding State Regulation 1200-8-6-.05(14). In addition, company policies regarding admission, readmission, bed hold, transfer and discharge procedures, and involuntary discharge policies were reviewed. This in service was conducted during the facility monthly Quality Assurance Performance Improvement (QAPI) meeting on November 13, 2012.

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Medical record review of a Nurses Note dated August 22, 2012 at 1300 (1:00 PM) documented "Pt transported to (named in patient Psyche hospital) ...Daughter here at time of transfer..."

Medical record review of a Care Plan dated June 7, 2012 documented "Resident discharge plan - return home with family." There was no documentation on the Care Plan of an update to the resident's discharge plans since June 7, 2012.

Medical record review of an Interdisciplinary Care Conference Attendance Record dated June 6, 2012 documented "Family unsure of d/c (discharge) plans at this (symbol for time)." The facility presented no additional documentation of Care Conferences with Resident #1's family.

The facility did not provide documentation that a 30 day involuntary discharge notice was given to Resident #1's family.

Review of the hospital Social Worker (SW) Notes dated September 6, 2012 at 12:34 pm documented "Received notification that (named facility) will not accept pt (patient) back at d/c from (named hospital). Placed call to (facility) admissions coordinator...to discuss why pt cannot return. She reports they likely cannot accept pt due to "outbursts." She states pt was at their facility as private pay, and their administrator will call me (Social Worker) to inform of plan."

Review of a hospital SW Note dated September 7, 2012 at 10:00 am documented "Followed up with (named facility's admission coordinator) at (named facility) again today as a return call was not made by (named facility's admission

4) A performance improvement plan was initiated on October 9, 2012 regarding discharge notification to family per company policy and was modified on November 13, 2012 during QAPI meeting to reflect auditing for compliance of discharged residents for three (3) months, including September, October, and November 2012. Administrator will monitor for compliance through QAPI meetings in November, and December 2012 and subsequent performance improvement plans will be developed and implemented as needed.

Completion Date 11/27/12
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>TN9502</td>
<td>A. BUILDING</td>
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**DATE SURVEY COMPLETED**

C

**10/24/2012**

**NAME OF PROVIDER OR SUPPLIER**

LEBANON HEALTH AND REHABILITATION CEF

**STREET ADDRESS, CITY, STATE, ZIP CODE**

731 CASTLE HEIGHTS COURT
LEBANON, TN 37087

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<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<td>N 531</td>
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<td>N 531</td>
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coordinator) yesterday as promised. Spoke with (named facility's admission coordinator) and she relayed that the DON (Director of Nursing) has decided not to accept pt back due to dementia and 'needing a better long term placement.' MSW (Master Social Worker) talked with (named facility's admission coordinator) about the patient's right to remain at their facility until a better fit is located. She (named facility's admission coordinator) asked that I (Social Worker) speak directly with DON regarding my concerns. Spoke with ...DON...and she reinforced (named facility's admission coordinator)’s statements that pt is not a 'good fit' for their facility due to dementia. It was explained that this pt maintains the same rights as a patient without dementia, and their facility should be assisting this pt/family with locating a facility that is a better fit. Explained that because of their refusal to accept this patient's return, the Ombudsman will need to be contacted."