| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105822 | A. Building<br>B. Wing | 12/10/2024 |

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| Gardens Healthcare & Rehabilitation Center | 1704 Huntington Village Circle<br>Daytona Beach, FL 32114 |

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility Transfer and Discharge policy review, the facility failed to provide a 30-day notice of discharge for one (Resident #1) of 2 residents reviewed for facility-initiated discharges, from a total of 4 residents sampled. As a result of the swift discharge from what had become Resident #1's home, he experienced sadness, loss and regret, and had insufficient time to plan for discharge to another location that would meet his physical, emotional and psychosocial needs.<br><br>The findings include:<br><br>A closed record review for Resident #1 revealed he was admitted to the facility on [DATE] and was [AGE] years old. He was discharged on 10/23/24. His diagnoses included paraplegia, hypertension, polyneuropathy, neurogenic bowel, neuromuscular dysfunction of bladder and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #1 with a brief interview for mental status (BIMS) score of 15, indicating he was cognitively intact.<br><br>A review of the Discharge Return Not Anticipated MDS assessment dated [DATE], revealed Resident #1 had an unplanned discharge on this same date to a short-term general hospital. Resident #1 was independent with daily decision making and required some assistance with activities of daily living. Discharge planning for him to return to the community was not occurring while he was in the facility.<br><br>A record review of the physician's order for Resident #1 revealed an order for him to be sent to the ER (emergency room) for evaluation and treatment. (Photographic evidence was obtained)<br><br>Review of the document titled AHCA Nursing Home Transfer and Discharge Notice revealed Resident #1 was transferred to a local hospital. The date the notice was given was 10/23/24, with an effective date 10/23/24, not the required 30-day notice of discharge.<br><br>Further record review revealed that the Resident Representative section of the transfer form for Resident #1 was shown as unable to sign. and the reason for Transfer/Discharge was listed as Your needs cannot be met in this facility. (Photographic evidence was obtained)<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a Psychiatry Phone Note dated 10/23/24 read: This provider was notified that resident was admitted to hospital as a [NAME] Act (a law that allows for involuntary examination and treatment for people who may have a mental illness and are a danger to themselves or others). It was reported to provider that patient had sent a message to his wife late Tuesday night, very early Wednesday morning, a suicide note. Staff reports that wife called the facility for staff to check on patient. Upon walking into his room, they noticed resident had tied his phone cord to the trapeze above his bed in attempt to hang himself. Staff cut the cord immediately and patient was able to respond and was still conscious. Per staff, patient will not be returning to this facility. Still in the hospital at this time. (Photographic evidence was obtained)<br><br>Review of the document titled Nursing Home to Hospital Transfer for Resident #1 dated 10/23/24 at 4:00 am reported he was being sent to the hospital for choking with phone cord wrapped around his neck. Resident's head was observed hanging from a phone type charger, which was around his neck and tied to a trapeze bar above his head. His face was purple, eyes were bulging and the resident was groaning. The cord was cut with scissors. Bleeding was noted from the resident's mouth and nose. Called 911. Resident stated he was trying to commit suicide. (Photographic evidence was obtained)<br><br>A telephone interview was conducted with Resident #1's spouse and Power of Attorney on 12/10/24 at 1:30 pm. She stated she had received a text from Resident #1. He was in distress, so she called the facility. Staff checked on him, found him in distress and transported him (to the hospital). She called the facility a few hours later and spoke with a staff member in the finance department and begged that the facility please not give away his room. Resident #1 wanted to return to the facility because emotionally it was good for him. He had his own private room there and a great rapport with the staff. A few hours later she received a phone call from the Administrator, who advised her that under the circumstances, she would have to come get Resident #1's belongings. So, she did. While at the facility she sat in the conference room with the Administrator and another facility staff member. Resident #1's wife said, [Resident #1] was not hurting ANYONE there, until that moment when he was in an emotional crisis. The facility just didn't want him back because of that incident. Resident #1 remained in the hospital for a little over three weeks, longer than he should have. The staff there told her after day two he didn't need to be there, but he had a urinary tract infection and was septic (infection in the blood) from it. Because of that, he was not allowed to participate in any counseling at the hospital. The psychiatric doctor told her he was not worried about Resident #1, but not once did he get counseling. Resident #1 was finally discharged once his illness resolved, but it was then they had to find someplace for him to go. That took a while. She stated the staff had loved him at the facility. He had been there 6 months. He was not ready to come home yet but was working on that. Resident #1 was happy with the physical therapy department and they would go in and work with him specifically. He also could use the machines in the gym to maintain his strength even though he was not on active PT caseload. Resident #1 was really upset that he was not going back. He wanted his room and the PT he was getting. Resident #1's wife began to cry at this point in the conversation. Resident #1 was currently at another local nursing home. We are not thrilled about it. She cried again as she explained the attempt on his life was unprecedented. That was SO not like him; it was a shock. She concluded by again saying, The staff here LOVED him, I mean they LOVED him.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A telephone interview was conducted with the receiving hospital's Clinical Supervisor (CS) on 12/10/24 at 2:10 pm. The hospital's Psychiatric Counselor (PC) was also on the call. The PC stated Resident #1 was sent to them under the [NAME] Act, and the facility refused readmission. Because they anticipated pushback from the facility, they started working on discharging him earlier, but the facility said no. The CS reported that it was Resident #1's wife who told them she had been told to come get Resident #1's belongings the day he was transferred to the hospital. The CS asked the Administrator if he was willing to be fined by the Centers for Medicare and Medicaid services (CMS, a federal agency) and mentioned that the fines could be steep for refusing to allow the resident to return. The Administrator said yeah. It sounded like the decision was over his head, and he understood it was a tough decision to make. The CS stated that the text Resident #1 sent was at 2:00 am. Staff ran, got him off of the [Hoyer] and there were no other patients who saw it. The CS said he and the PC felt it was a very inappropriate refusal, and that Resident #1 had made it very clear he had wanted to go back to the facility. The PC concluded, stating Resident #1 realized his action had an impact and he could not go back to the facility. It affected him strongly at first, realizing that his life had changed so much related to the surgery that left him paralyzed. Then, realizing he could not go back to what was his home. That was one more thing for him to come off of. The resident's wife was definitely upset.<br><br>A telephone interview was conducted with Resident #1 on 12/10/24 at 2:20 pm. He confirmed he was discharged from the facility and not allowed to come back. He was unfortunately at another nursing home now. The overall culture at the former facility was Let's take care of patients. The facility was wonderful; full of people who cared. He stated he so regretted not being there anymore and referred to the care as excellent. Resident #1 humbly explained his suicide attempt was during a desperate time, and he did a stupid thing. He became tearful as he explained he had an emotional breakdown, and it all came crashing down on him. The (new) facility was just not giving him what he needed as far as care. He said, It just isn't very good. Furthermore, there was very limited equipment in the therapy gym. Resident #1 learned almost immediately after his transfer that he would not be allowed back. He wanted to return but was told he couldn't. They packed up all his stuff and left it for his wife to retrieve. Wham, bam, thank you ma'am, he was out of there. Resident #1 said he was supposed to receive a 30-day notice, but the facility was willing to pay a fine just to get it over with. Resident #1 concluded by saying he did not want to be where he was now and asked if there was any way the facility could be forced to take him back.<br><br>An interview was conducted with the Administrator on 12/10/24 at 2:45 pm. The Director of Nursing joined him for the interview. The Administrator explained Resident #1 had been in the facility since April. He had come in as skilled (needing skilled nursing services), and they tried to get Resident #1 to where he could go home with the assistance of his wife. He wasn't strong enough yet. Prior to admission, Resident #1 had been a golfer and having back pain for a while. His friend, a surgeon, convinced Resident #1 to get back surgery and performed the operation. The surgery resulted in Resident #1 becoming paralyzed. Resident #1 was in a private room, so that made him happy. He was always polite, with no major issues.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The DON interjected and explained Resident #1 was well-liked; he would talk with the staff and goof around. This incident was a total change for him. Resident #1's wife received an email from him late at night. She opened it and called the facility immediately. The wife advised the staff who answered that Resident #1 might commit suicide. Staff immediately went to the room and upon entry, saw him hanging from a telephone cord tied to his over-bed trapeze. Staff took scissors and immediately cut him down. There were no signs that would happen, and the wife had never voiced any similar concerns. Resident #1 had been seen by psych, and no antecedents were identified. Resident #1 was upset with the staff and told medics he was fading but the staff stopped it. Resident #1 was very close with the staff. It was traumatic.<br><br>The Administrator said after finding Resident #1, emergency medical technicians were called. They arrived and Baker-Acted Resident #1. The facility assessed the situation and decided not to have Resident #1 return. The facility was not going to be able to meet his needs based on his wanting to harm himself. Facility staff followed him in the hospital for days, but nothing changed. Resident #1 was making no progress and refusing his antidepressants. They notified Resident #1's wife, who asked to come get his belongings. She realized he was not coming back. Ultimately, the Administrator signed off on the decision not to readmit Resident #1, but he certainly doesn't make those decisions alone. Clinical and Regional staff decided to deny Resident #1's return. The Administrator was asked if they considered providing a 30-day notice and one-to-one staffing supervision for the 30-day period leading up to discharge (or appeal hearing) in order to keep Resident #1 safe. The Administrator said they contemplated it, but decided no. He stated the facility sent a 30-day discharge notice to the hospital, but was reminded the date on the notice was the same day of the transfer, not 30 days later. The Administrator said the staff felt they might have been able to do something earlier to stop this resident. Ultimately, he felt he could not keep Resident #1 safe from himself.<br><br>A telephone interview was conducted with Long Term Care Ombudsman (LTCO) A on 12/10/24 at 1:15 pm. She stated she was just talking with LTCO B, who handles discharges. She said she called the Administrator after this discharge and advised him he needed to accept Resident #1 back per the 30-day discharge notice requirements. The Administrator replied that he would not allow Resident #1 back per his and corporate's decision, as it was not in the best interest of this resident. She reminded him again he needed to take Resident #1 back, and he said no again. When the LTCO spoke with Resident #1 while he was still in the hospital, he told her he wanted to return to the facility.<br><br>Review of the facility's policy Standards and Guidelines: Transfer and Discharge Implemented/Reviewed/Revised: 1/1/21 found it states:<br><br>Standard: It is the standard of this facility to provide appropriate transfer and discharge services . The facility will allow for sufficient preparation and orientation by informing the resident where he or she is going to take steps to minimize anxiety.<br><br>Guidelines:<br><br>1. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br><br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility .<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2. 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.<br><br>- Page #2: 30 Day Facility Initiated Discharges (Notice Requirements Before Transfer/Discharge):<br><br>1. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-term Care Ombudsman.<br><br>2. The facility should record the reasons for the transfer or discharge in the resident's medical record and include in the notice the following items:<br><br>1)The reason for transfer or discharge;<br><br>[1)] The effective date of transfer or discharge;<br><br>2) The location to which the resident is transferred or discharged ;<br><br>3) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>4) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>5) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency<br><br>responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 and;<br><br>3. The Notice of Transfer or Discharge should be made by the facility at least 30 days before the resident is transferred or discharged except under the following circumstances: The Notice must be made as soon as practicable before transfer or discharge when-<br><br>a. The safety of individuals in the facility would be endangered;<br><br>b. The health of individuals in the facility would be endangered;<br><br>c. The resident's health improves sufficiently to allow a more immediate transfer or discharge;<br><br>d. An immediate transfer or discharge is required by the resident's urgent medical needs; or<br><br>e. A resident has not resided in the facility for 30 days.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Unplanned Discharges/Emergency Transfers to Hospital:<br><br>1. When a change in condition or required transfer to the hospital or other higher level of care is determined, the facility should obtain appropriate transfer orders .<br><br>2. Documentation of the change should be reflected in the medical record .<br><br>5. In situations where the facility has decided to discharge the resident while still hospitalized , the facility will send a notice of the discharge to the resident and resident representative . (Photographic evidence was obtained)<br><br>. |

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility Resident Return to Facility document review, the facility failed to permit one resident who was admitted for long-term care (Resident #1) to return to the facility following a [NAME] Act transfer to the hospital from a total of two residents reviewed for transfer/discharge. The abrupt discharge for Resident #1 caused him to experience sadness, loss and regret, and gave insufficient time to plan for discharge to another location of his choice that would meet his physical, emotional and psychosocial needs.<br><br>The findings include:<br><br>A closed record review for Resident #1 revealed he was admitted to the facility on [DATE] and was [AGE] years old. He was discharged on 10/23/24. His diagnoses included paraplegia, hypertension, polyneuropathy, neurogenic bowel, neuromuscular dysfunction of bladder and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #1 with a brief interview for mental status (BIMS) score of 15, indicating he was cognitively intact.<br><br>A review of the Discharge Return Not Anticipated MDS assessment dated [DATE], revealed Resident #1 had an unplanned discharge on this same date to a short-term general hospital. Resident #1 was independent with daily decision making and required some assistance with activities of daily living. Discharge planning for him to return to the community was not occurring while he was in the facility.<br><br>A record review of the physician's order for Resident #1 revealed an order for him to be sent to the ER (emergency room) for evaluation and treatment. (Photographic evidence was obtained)<br><br>Review of the document titled AHCA Nursing Home Transfer and Discharge Notice revealed Resident #1 was transferred to a local hospital. The date the notice was given was 10/23/24, with an effective date 10/23/24, not the required 30-day notice of discharge.<br><br>Further record review revealed that the Resident Representative section of the transfer form for Resident #1 was shown as unable to sign. and the reason for Transfer/Discharge was listed as Your needs cannot be met in this facility. (Photographic evidence was obtained)<br><br>Review of a Psychiatry Phone Note dated 10/23/24 read: This provider was notified that resident was admitted to hospital as a [NAME] Act (a law that allows for involuntary examination and treatment for people who may have a mental illness and are a danger to themselves or others). It was reported to provider that patient had sent a message to his wife late Tuesday night, very early Wednesday morning, a suicide note. Staff reports that wife called the facility for staff to check on patient. Upon walking into his room, they noticed resident had tied his phone cord to the trapeze above his bed in attempt to hang himself. Staff cut the cord immediately and patient was able to respond and was still conscious. Per staff, patient will not be returning to this facility. Still in the hospital at this time. (Photographic evidence was obtained)<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the document titled Nursing Home to Hospital Transfer for Resident #1 dated 10/23/24 at 4:00 am reported he was being sent to the hospital for choking with phone cord wrapped around his neck. Resident's head was observed hanging from a phone type charger, which was around his neck and tied to a trapeze bar above his head. His face was purple, eyes were bulging and the resident was groaning. The cord was cut with scissors. Bleeding was noted from the resident's mouth and nose. Called 911. Resident stated he was trying to commit suicide. (Photographic evidence was obtained)<br><br>Review of the document tilted Bed Hold Notice for Resident #1 dated 10/23/24 advised the notice was provided because resident was admitting to the hospital. It stated the facility policy was to remind of the bed-hold information. If the facility stay was paid by Medicaid, the bed would be held at no extra cost to the resident for a maximum of 8 days in a calendar month while hospitalized . If hospitalized beyond that time frame, private funds must be used to pay for and extended hold . if you do not hold your bed and wish to return to the facility, you will be allowed to return to your previous room, if available, or to the first available bed in a semi-private room. This is conditioned upon requiring services and your eligibility . You and your representative must verify that you wish to have your bed held within 24 hours of being admitted to the hospital or your bed will be relinquished . The form was signed by the facility but the resident's signature box stated, Unable to sign. (Photographic evidence was obtained)<br><br>No documentation in the record was found reflecting communication between the facility and the receiving hospital during Resident #1's stay.<br><br>A telephone interview was conducted with Resident #1's spouse and Power of Attorney on 12/10/24 at 1:30 pm. She stated she had received a text from Resident #1. He was in distress, so she called the facility. Staff checked on him, found him in distress and transported him (to the hospital). She called the facility a few hours later and spoke with a staff member in the finance department and begged that the facility please not give away his room. Resident #1 wanted to return to the facility because emotionally it was good for him. He had his own private room there and a great rapport with the staff. Then a few hours later she received a phone call from the Administrator, who advised her that under the circumstances, she would have to come get Resident #1's belongings. So, she did. While at the facility she sat in the conference room with the Administrator and another facility staff member. Resident #1's wife said, [Resident #1] was not hurting ANYONE there, until that moment when he was in an emotional crisis. The facility just didn't want him back because of that incident. Resident #1 remained in the hospital for a little over three weeks, longer than he should have. The staff there told her after day two he didn't need to be there, but he had a urinary tract infection and was septic (infection in the blood) from it. Because of that, he was not allowed to participate in any counseling at the hospital. The psychiatric doctor told her he was not worried about Resident #1, but not once did he get counseling. Resident #1 was finally discharged once his illness resolved, but it was then they had to find someplace for him to go. That took a while. She stated the staff had loved him at the facility. He had been there six months. He was not ready to come home yet but was working on that. Resident #1 was happy with the physical therapy department and they would go in and work with him specifically. He also could use the machines in the gym to maintain his strength even though he was not on active PT caseload. Resident #1 was really upset that he was not going back. He wanted his room and the PT he was getting. Resident #1's wife began to cry at this point in the conversation. Resident #1 was currently at another local nursing home. We are not thrilled about it. She cried again as she explained the attempt on his life was unprecedented. That was SO not like him; it was a shock. She concluded by again saying, The staff here LOVED him, I mean they LOVED him.<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A telephone interview was conducted with the receiving hospital's Clinical Supervisor (CS) on 12/10/24 at 2:10 pm. The hospital's Psychiatric Counselor (PC) was also on the call. The PC stated Resident #1 was sent to them under the [NAME] Act, and the facility refused readmission. Because they anticipated pushback from the facility, they started working on discharging him earlier, but the facility said no. The CS reported that it was Resident #1's wife who told them she had been told to come get Resident #1's belongings the day he was transferred to the hospital. The CS asked the Administrator if he was willing to be fined by the Centers for Medicare and Medicaid services (CMS, a federal agency) and mentioned that the fines could be steep for refusing to allow the resident to return. The Administrator said yeah. It sounded like the decision was over his head, and he understood it was a tough decision to make. The CS stated that the text Resident #1 sent was at 2:00 am. Staff ran, got him off of the [Hoyer] and there were no other patients who saw it. The CS said he and the PC felt it was a very inappropriate refusal, and that Resident #1 had made it very clear he had wanted to go back to the facility. The PC concluded, stating Resident #1 realized his action had an impact and he could not go back to the facility. It affected him strongly at first, realizing that his life had changed so much related to the surgery that left him paralyzed. Then, realizing he could not go back to what was his home. That was one more thing for him to come off of. The resident's wife was definitely upset.<br><br>A telephone interview was conducted with Resident #1 on 12/10/24 at 2:20 pm. He confirmed he was discharged from the facility and not allowed to come back. He was unfortunately at another nursing home now. The overall culture at the former facility was Let's take care of patients. The facility was wonderful; full of people who cared. He stated he so regretted not being there anymore and referred to the care as excellent. Resident #1 humbly explained his suicide attempt was during a desperate time, and he did a stupid thing. He became tearful as he explained he had an emotional breakdown, and it all came crashing down on him. The (new) facility was just not giving him what he needed as far as care. He said, It just isn't very good. Furthermore, there was very limited equipment in the therapy gym. Resident #1 learned almost immediately after his transfer that he would not be allowed back. He wanted to return but was told he couldn't. They packed up all his stuff and left it for his wife to retrieve. Wham, bam, thank you ma'am, he was out of there. Resident #1 said he was supposed to receive a 30-day notice, but the facility was willing to pay a fine just to get it over with. Resident #1 concluded by saying he did not want to be where he was now and asked if there was any way the facility could be forced to take him back.<br><br>An interview was conducted with the Administrator on 12/10/24 at 2:45 pm. The Director of Nursing joined him for the interview. The Administrator explained Resident #1 had been in the facility since April. He had come in as skilled (needing skilled nursing services), and they tried to get Resident #1 to where he could go home with the assistance of his wife. He wasn't strong enough yet. Prior to admission, Resident #1 had been a golfer and having back pain for a while. His friend, a surgeon, convinced Resident #1 to get back surgery and performed the operation. The surgery resulted in Resident #1 becoming paralyzed. Resident #1 was in a private room, so that made him happy. He was always polite, with no major issues.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105822 | A. Building<br>B. Wing | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gardens Healthcare & Rehabilitation Center | 1704 Huntington Village Circle<br>Daytona Beach, FL 32114 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The DON interjected and explained Resident #1 was well-liked; he would talk with the staff and goof around. This incident was a total change for him. Resident #1's wife received an email from him late at night. She opened it and called the facility immediately. The wife advised the staff who answered that Resident #1 might commit suicide. Staff immediately went to the room and upon entry, saw him hanging from a telephone cord tied to his over-bed trapeze. Staff took scissors and immediately cut him down. There were no signs that would happen, and the wife had never voiced any similar concerns. Resident #1 had been seen by psych, and no antecedents were identified. Resident #1 was upset with the staff and told medics he was fading but the staff stopped it. Resident #1 was very close with the staff. It was traumatic.<br><br>The Administrator said after finding Resident #1, emergency medical technicians were called. They arrived and Baker-Acted Resident #1. The facility assessed the situation and decided not to have Resident #1 return. The facility was not going to be able to meet his needs based on his wanting to harm himself. Facility staff followed him in the hospital for days, but nothing changed. Resident #1 was making no progress and refusing his antidepressants. They notified Resident #1's wife, who asked to come get his belongings. She realized he was not coming back. Ultimately, the Administrator signed off on the decision not to readmit Resident #1, but he certainly doesn't make those decisions alone. Clinical and Regional staff decided to deny Resident #1's return. The Administrator was asked if they considered providing a 30-day notice and one-to-one staffing supervision for the 30-day period leading up to discharge (or appeal hearing) in order to keep Resident #1 safe. The Administrator said they contemplated it, but decided no. He stated the facility sent a 30-day discharge notice to the hospital, but was reminded the date on the notice was the same day of the transfer, not 30 days later. The Administrator said the staff felt they might have been able to do something earlier to stop this resident. Ultimately, he felt he could not keep Resident #1 safe from himself.<br><br>A telephone interview was conducted with Long Term Care Ombudsman (LTCO) A on 12/10/24 at 1:15 pm. She stated she was just talking with LTCO B, who handles discharges. She said she called the Administrator after this discharge and advised him he needed to accept Resident #1 back per the 30-day discharge notice requirements. The Administrator replied that he would not allow Resident #1 back per his and corporate's decision, as it was not in the best interest of this resident. She reminded him again he needed to take Resident #1 back, and he said no again. When the LTCO spoke with Resident #1 while he was still in the hospital, he told her he wanted to return to the facility.<br><br>Review of the facility's standard Standards and Guidelines: Resident Return to Facility implemented 1/1/21, reviewed/revised 1/1/24 found it states:<br><br>Standard:<br><br>It will be the standard of this facility to allow residents to be readmitted per federal and state guidelines unless the resident is deemed inappropriate to be re-admitted to the facility for the following reasons:<br><br>1.<br><br>The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.<br><br>2.<br><br>(continued on next page) |

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| | 105822 | A. Building<br>B. Wing | 12/10/2024 |

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| Gardens Healthcare & Rehabilitation Center | 1704 Huntington Village Circle<br>Daytona Beach, FL 32114 |

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The resident's health has improved sufficiently so that the resident no longer needs the services of the facility.<br><br>3.<br><br>The resident's clinical or behavioral status endangers the safety of individuals in the facility.<br><br>4.<br><br>The resident's clinical or behavioral status endangers the health of individuals in the facility.<br><br>5.<br><br>The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility.<br><br>6.<br><br>The facility ceases to operate.<br><br>Guidelines:<br><br>1. The process for readmission of a resident following rehospitalization or therapeutic leave should be followed per the facility bed hold and transfer and discharge policies .<br><br>4. The facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:<br><br>-Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.<br><br>-Ascertain an accurate status of the resident's condition-this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.<br><br>-Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.<br><br>-Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;<br><br>-Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs .<br><br>6. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility. (Photographic evidence was obtained)<br><br>. |