STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515163	A. BUILDING _____ B. WING _____	C 12/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT DAWNVIEW LLC	1 DIANE DRIVE PO BOX 686

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F 000	INITIAL COMMENTS Complaint reference #2-8319 Unsubstantiated complaint record with no related deficiencies cited. --- Complaint reference #2-8343 Substantiated complaint record with deficiencies cited. .	F 000		
F 203 SS=G	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered	F 203		01/19/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/21/2009

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.

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under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.

The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Based on record review, resident interview, staff interview, and other interviews, the facility failed to provide a written thirty-day advance notice of discharge (including the reason for the discharge, the date of the discharge, and the resident's right to appeal the discharge decision) to the resident, a family member, or the resident's responsible party in a timely manner

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for one (1) of two (2) sampled residents.

Resident #22 was transferred to the hospital on the morning of 12/08/08 using non-emergency transport. While she was at the hospital, on 12/09/08, the facility's social worker verbally notified Resident #22's brother-in-law [not the resident, who was alert and oriented, nor the resident's sister / MPOA representative] that the resident had been discharged from the facility and her possessions had been packed and were ready to be picked up. The facility failed to provide a written notice of the facility-initiated discharge at least thirty (30) days in advance of the effective date of the discharge action, specifying the effective date of the discharge or the reason for the discharge, nor was she permitted on opportunity to request an appeal of the discharge action from the State Board of Review.

On 12/09/08, upon learning from her brother-in-law that she had been discharged from the facility, Resident #22 reported she was so upset about losing her "home of three years" that she could not talk, and she gave the phone to the hospital's social worker to finish the conversation; this was confirmed through an interview with hospital's social worker.

When the resident's sister / MPOA representative offered, at 3:30 p.m. on 12/09/08, to pay the facility to hold Resident #22's bed during her hospital stay, she was told by the facility's social worker that Resident #22's bed had already been given to someone else.

This deficient practice resulted in actual harm to Resident #22, who expressed mental anguish upon learning she had lost her "home of three

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years". Resident identifier: #22. Facility census: 63.

Findings include:

a) Resident #22

1. A review of the resident's medical record revealed Resident #22 was a 61-year old female who had been determined by her physician to have the capacity to make her own informed medical decisions. She also had also executed a medical power of attorney (MPOA), designating her sister to serve as her MPOA representative in the event she would become incapacitated, and the sister's contact information was noted in the resident's clinical record. A review of nursing notes and social service notes revealed staff was aware of the frequent visits by the resident's sister and of her participation in the resident's care.

2. In a nursing entry dated 12/08/08 at 2:50 p.m., the licensed practical nurse (LPN - Employee #3) noted, "At 0900 (9:00 a.m.) this writer went in to get vitals on this resident, she was wheezing and C/O (complained of) SOB (shortness of breath), resident was on 2/L (two liters) of O2 (oxygen) . . . Dr. (name) was called, at 0915, this writer wanted to (page change) Cont. be sent out, Dr. (name) said to send resident out. . . . resident was picked up at 0955 approx. (approximately). . . POA (power of attorney) was called and message was left for POA to call back." A subsequent entry by another nurse (Employee #13), at 4:30 p.m., recorded, "POA called back and is aware of transfer / admission to (name of hospital)."

3. In an interview with Resident #22 via

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telephone at 5:08 p.m. on 12/09/08 (while she was in the hospital), she stated she had not spoken to the facility's administrator or social worker prior to her transfer to the hospital. According to Resident #22, no staff member had discussed anything with her about whether she wished to pay privately to hold her bed, although she reported that, about two (2) months ago, the social worker told her she had exhausted all her Medicaid bedhold days. But, she stated, following that discussion, she had another hospital admission, during which she was not required to pay for a bedhold and after which she was permitted to return to the nursing facility.

Review of the resident's admission / discharge records at the nursing facility verified the facility held her bed open during a hospital admission from 10/07/08 to 10/10/08 without charging her for a bedhold. This was also confirmed in an interview with the facility's social worker at 9:00 a.m. on 12/10/08.

The resident further stated she was told by her brother-in-law this afternoon (12/09/08) that her belongings had been gathered up and her bed at the nursing facility had been given away to a new admission. She reported having then called the facility, at which time the facility's administrator told her she was discharged but that she could put the resident on the waiting list. The resident reported she was so upset about losing her "home of three years" that she could not talk and gave the phone to the hospital's social worker to finish the conversation. She did instruct the hospital's social worker later that this facility was her first choice when she was discharged from the hospital.

4. During an interview with two (2) nurses at the

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facility (Employees #14 and #3) at 9:30 a.m. on 12/10/08, they stated they were caring for Resident #22 at the time of her transfer; they verified the resident was alert and oriented at the time of transfer and was sent to the hospital by non-emergency ambulance. Both nurses denied having any discussion with the resident regarding her bedhold status, and neither of them had spoken with any family member about a bedhold.

At 11:15 a.m. on 12/10/08, Employee #14 returned and reported that, when Resident #22 was leaving the facility, she handed her a packet of forms which was always given to a resident when going to the hospital. When asked what was in the packet, she said she knew it contained a transfer sheet and chart information required by the hospital. The packets were prepared in advance by the unit clerk and placed in a drawer, and the nurses would just get one out and give it to the resident. This was verified by a unit clerk in the presence of the administrator at the nursing station at 11:30 a.m., where multiple packets were observed in a file drawer. The transfer form was the top form on the packets that were observed.

5. During an interview with the administrator and the interim director of nursing at 9:00 a.m. on 12/10/08, the administrator stated Resident #22 had been discharged from the facility, because she was covered by Medicare at the time of transfer to the hospital, and because the social worker had told her, at their morning meeting on 12/09/08, that the resident had no way to pay privately for a bedhold. She acknowledged that neither she nor the facility's social worker had spoken to the resident either prior to or after transfer, but she stated she understood the hospital's social worker was to inform the

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resident of her discharge from the nursing facility.

The facility's social worker, after being called into this meeting, stated he had phoned the resident's sister / MPOA representative on the morning of 12/09/08 and left her a message. Her husband returned the call at 2:30 p.m. that same day and said his wife was out of town but would be contacted. The social worker informed him that the resident's belongings had been collected and could be picked up, as she had been discharged. The resident's MPOA representative contacted the nursing home at 3:30 p.m. and stated she would pay for the resident's bedhold, but she was informed by the social worker that the resident's bed had already been promised to a new admission.

6. In an interview with the hospital's social worker at 10:30 a.m. on 12/10/08, she was asked when she had been notified about Resident #22's discharge from the nursing facility and if she had informed the resident of this discharge. She stated that staff from the nursing facility had contacted her on the morning of 12/09/08 and told her to wait until 12/10/08 to do anything, as they had no one waiting for the bed at that time and they would wait to hear about the resident's condition. She was out of the office for a while, and when she returned in the afternoon, she had a telephone message from the nursing facility about the discharge. She stated she did not inform Resident #22 of the bedhold or the discharge, saying, "No. This is not my responsibility, and I would not do it." She was in the resident's hospital room when Resident #22 called the nursing facility's administrator to question the discharge; she stated the resident was very upset. The hospital's social worker had since started the reapplication process on

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	Resident #22's behalf. 7. In a follow-up interview with the administrator at 11:30 a.m. on 12/10/08, she acknowledged that the practice of the facility was to inform the resident and the family member by mail when the bedhold could not be paid, and documentation indicated this was done. She had no comment about the short period of time that had lapsed between the resident's transfer to the hospital and the facility's decision to permanently discharge the resident, nor did she have any comment about the fact that the resident's MPOA representative had agreed to pay the bedhold. .			