DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 7/1/19 to 7/2/19. The survey was prompted by complaint intake WY00002862. The following common abbreviations are used through this document: Shahbaz: Certified Nurse Aide DON: Director of Nursing RN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (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.	F 622		

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

Michelle Craig | Administrator | 8/19/19

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.

8/23/19 - 2:35 pm - I Spoke with the administrator, Michelle Craig, and informed her the plan was accepted with alleged dates of compliance of 8/2/19 & 8/16/19.

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F 622	Continued From page 1 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. (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	F 622		

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F 622	Continued From page 2 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. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure a facility-initiated discharge was necessary for 1 of 1 sample residents (#1) who were issued a discharge notice. The findings were: 1. Review of the quarterly MDS assessment dated 5/27/19 showed resident #1 had a brief interview for mental status score of 12/15 (moderately impaired), verbal behavior symptoms directed at others on 1 to 3 days during the look back period, diagnoses which included diabetes	F 622	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. On 7/9/19 the facility issued a letter to resident #1, resident #1's representative, the regional ombudsman, and to the Wyoming Department of Health Healthcare Surveillance Branch, Aging Division, Health Care Licensing and Surveys to notify all parties of the facilities decision to rescind the discharge notice dated June 17, 2019 to be effective July 17, 2019 without prejudice.	08/02/19

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F 622	Continued From page 3 mellitus, malignant neoplasm of the colon, and malignant neoplasm of the uterus. Further review showed the resident required extensive assistance of 1 person for toilet use and dressing and limited assistance of 1 person for bed mobility and transfers. Review of a discharge notice dated 6/17/19 showed the family for the resident was issued a 30-day involuntary discharge notice with a plan to discharge the resident to the family member's home "unless other accommodations are made prior..." The reason for discharge was "continued medical non-compliance" and the family was to contact the facility social worker if they were in need of "in-home services." The following concerns were identified: a. Observation on 7/1/19 at 4:38 PM showed a shahbaz exited the resident's room with soiled linen in her hands and the resident followed in a wheelchair. The resident wheeled him/herself to the dining room table and read papers on the table. The resident returned to his/her room at 5 PM to get his/her glasses. No evidence of odor was noted at that time. Interview with the resident at that time revealed s/he had been at the facility for "a little while" and had to "move out" by July 17th. The resident was unsure why s/he was unable to stay at the facility. b. Review of a social services note dated 6/12/19 and timed 10:22 AM showed "...BIMS score is 12...Elder has become more difficult when it comes to [his/her] cares. Elder does not allow staff to perform [his/her] cares at times and refuses to use the restroom. Elder continues to curse at staff, calls them names and gives them the finger. When attempting to talk to elder about [his/her] behavior [s/he] will curse and yell and tell you to go to hell. IDT [interdisciplinary team] has met with elder and daughter. Elder has agreed to	F 622	How the facility will identify other residents having the potential to be affected by the same deficient practices: 1. Presently there is not a resident that the facility would consider issuing a 30-day discharge notice to. However, if one does occur the facility has developed a checklist to follow to ensure that all applicable documentation has occurred. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Administrator and Director of Nursing will review the facilities policy to ensure compliance with state and federal regulations and update the policy as necessary. 2. The Administrator will conduct a training with Social Worker and Director of Nursing regarding the facility's policy for issuing a 30-day discharge notice and the documentation necessary for a 30-day discharge notice. 2. The Social Worker will conduct an in-service with staff regarding documentation of behaviors, care refusals, and resident rights. 3. The Social Worker will develop a tool to be used when issuing a 30-day discharge notice to ensure all applicable documentation has occurred and all steps listed in the facility's policy has been followed. Applicable documentation includes, but is not limited to, reviewing the resident's care plan and the facility assessment to ensure that the facility has made the effort to meet the needs of the resident, documentation of the success or failure of attempted interventions, documentation provided to the resident and/or representative regarding risks of refusing treatments, and a physicians note supporting that the facility cannot meet the needs of the resident, an overview of the facilities attempts to meet the needs of the resident, and the specific services that the receiving facility can provide that the transferring facility cannot.	

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F 622	Continued From page 4 allow [his/her] brief to be changes [sic] every two hours and to take a bath twice a week. Elder s [sic] room has a bad odor due to elder urinating and soiling [him/herself]. Elder does have a UTI [urinary tract infection] which is being treated..." c. Review of a social services noted dated 6/17/19 and untimed showed "placed a call to [family member's name] (elders daughter) informing her of a 30 day discharge. [Family member's name] did not answer the phone. A message was left. Went and talked to [Resident's name]. Explained that a 30 day discharge would be given to [him/her] and one sent to [family member's name]. Elder asked why, I explained it was due to noncompliance with cares. Elder became angry and told me to leave her room. I attempted to let elder know that whatever I can do for [him/her] that I will do. I tried to tell her that my job is to assist [him/her] in an [sic] way I can. [S/he] stopped talking, told me to leave and returned to lying in her bed. DON was present during conversation." d. Review of a social services note dated 6/18/19 and untimed showed "took [sic] the discharge letter to elder. I explained what is [sic] was and asked if there was anything I could do. [S/he] states [s/he] is blind and could not read the letter. I attempted to read it to elder. [S/he] kept interrupting and saying [s/he] was being kicked out because [s/he] did not shower one time. I explained to [him/her] that it was not only that at our last meeting we discussed [his/her] care and [s/he] agreed to toileting every 2 hours and to bathes [sic] 2 times a week. [S/he] stated [s/he] did not agree to this. [S/he] told me to get out of her room. I ask [sic] her if [s/he] could be a little nicer. [S/he] told me [s/he] would be nice and put a foot up my ass. I continued to attempt to explain to elder that my job as a social worker is to assist	F 622	How the facility plans to monitor its performance to make sure that solutions are sustained: 1. This plan will be implemented, and the corrective action evaluated for its effectiveness. 2. The plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program and reviewed quarterly for effectiveness and compliance. 3. The Quality Assurance Manager will conduct audits monthly to ensure that all applicable documentation has occurred, and all steps of the facility's policy has been followed should a 30-day discharge notice be issued. Responsible: Social Worker	

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F 622	Continued From page 5 in any way I could for [him/her] to have a smooth discharge. [S/he] ask [sic] me where [s/he] was going and I again read [him/her] the letter saying we would discharge to [family member's name] home. [S/he] ask [sic] what if [family member's name] did not want [him/her]. Again I tried to explain to [him/her] if [s/he] would just listen and let me assist that I could work with [him/her] and find an appropriate place. [S/he] again got angry and told me [s/he] didn't need my help and [s/he] could live in a corner in an alley. I ask [sic] [him/her] to think about letting me help [him/her] and I would check on [him/her] again[sic] [S/he] stated I could help [him/her] by letting [him/her] put a foot up my ass and to leave [his/her] room." e. Review of a social services note dated 6/28/19 and untimed showed "Update on discharge planning.: [Name] from [facility name] called and requested information on elder. Paper work was sent on 6/20. 6/24 Called and left a message with [resident's family member]. No call back. Called [name] on 6/25 to see about admission. [Facility name] declined to accept elder stating elder has to [sic] many behaviors. 6/26 tried to talked [sic] to [resident's family member] about discharge when she came to get [resident] for lunch....6/27 talked to Ombudsman about discharge. Explained the reason for non compliance and behaviors. Elder is refusing bath and refusing toilet. .Explained [sic] that skin was going to breakdown. [Ombudsman name] stated that elder has a right to refuse. I let her know that elder had refused bathing so elder was only bathing once week [sic] but is now refusing any bath at times and is incontinent and refusing to be changed." f. Review of bathing record from 6/1/19 to 6/29/19 showed the resident was offered a bath on 9 occasions and refused 4 times. The	F 622		

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F 622	Continued From page 6 resident received a bath on 6/5/19, 6/12/19, 6/19/19, 6/22/19, and 6/26/19. g. Review of a progress note dated 6/11/19 and timed 5:18 AM showed "Shahbaz and Nurse assisted elder to restroom; elder was upset, told the shahbaz and nurse that [s/he] wants to 'shoot whoever gets [him/her] up at 4 in the morning'. Elder then refused to get off the toilet, it took 30 minutes to convince the elder to get off the toilet." h. Review of a progress note dated 6/13/19 and timed 6:10 PM showed "Elder threatened to hit another elder at the dining room table at dinner time. When asked why [s/he] would would make that kind of threat [s/he] stated "why wouldn't I?" When explained that its inappropriate, [s/he] gave the Shahbaz the finger." i. Review of a progress note dated 6/14/19 and timed 8:12 AM showed "met with elder who was threatened. [S/he] has no recall of this. Talked to resident [#1] and explained why I was here in the evening. [S/he] stated "I have never hit anyone". [sic] I told [him/her] that [s/he] had threatened another elder. [S/he] insisted [s/he] did not say this. I told [him/her] that when staff talked to [him/her] [s/he] told them [s/he] did. Again elder stated [s/he] did not say this. At this time I am unclear as to if this was said and elder does not remember. Elder has had a UTI and is on medication. No report filed with the state due to one elder not remembering and another elder stating [s/he] did not say this. Also talked to resident who sits by [resident #1] at the table and is able to remember statements. This elder was unable to recall if anything was said..." j. Review of a progress note dated 6/14/19 and timed 12:18 PM showed "Elder was prompted to use the bathroom in the morning and refused. Before lunch elder had rang for	F 622		

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F 622	Continued From page 7 assistance. When staff had entered room, there was loose BM on elders bed, floor, wheelchair, shoes, socks, nightgown, and toilet seat. Staff had mentioned again the toileting schedule and that these accidents would be avoided if [s/he] would use the restroom when prompted. Elder got upset and said [s/he] refuses to do a toileting schedule because [s/he] feels [s/he] doesn't get enough sleep. Nurse was notified." k. Review of a progress note dated 6/26/19 and timed 2:37 AM showed "Elder was woke up at 0200 rounds to use the restroom. When told [s/he] had to get up because [his/her] brief was wet, [s/he] started calling staff names such as 'idiot, stupid' [sic] and saying 'Don't speak unless you have something intelligent to say' because [s/he] dribbles and [s/he] stated [his/her] brief is always wet. [S/he] did get up and go to the bathroom, and after nurse visited with [him/her], [s/he] did calm down. When getting back to bed, [s/he] said [his/her] brief was wet, to which this nurse offered to assist [him/her] back to the bathroom. [S/he] just laugher at this response and said [s/he] was going to bed." l. Review of the resident's care plan, last revised on 4/22/19, showed the resident had a cognitive deficit, was at risk for falls, was a diabetic, and needed assistance to maintain his/her current level of function with mobility and ADLs. There was no evidence a care plan was developed related to resident behaviors, bathing, discharge planning, toileting, or resident preferences. m. Interview with the administrator, DON, and social services director on 7/2/19 at 10:37 AM revealed the resident was issued a discharge notice for "medical non-compliance" as the resident did not "like to bathe" and refused to go to the bathroom or receive incontinence care.	F 622		

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F 622	Continued From page 8 The facility revealed a toileting diary or toileting assessment had not been completed to determine the appropriate toileting plan, they were unsure if the resident had a preferred time of day to shower, the resident had not been evaluated by a physician, and they had no documentation of previously attempted interventions. Further interview confirmed a care plan had not been developed for the resident related to behaviors, hours of sleep, preferences, toileting, or bathing. n. Review of the policy titled "Documentation of Transfers/Discharges" received from the facility administrator on 7/2/19 showed "When an elder is transferred or discharged, his or her medical records shall be documented as to the reasons why such action was taken...1. All documentation concerning the transfer or discharge of an elder must be recorded in the elder's medical record. 2. Should the elder be transferred or discharged for the following reasons, the basis for the transfer or discharge must be documented in the elder's clinical record by the elder's attending physician: a. the transfer or discharge is necessary for the elder's welfare, and the elder's needs cannot be met in the facility; or b. The transfer or discharge is appropriate because the elder's health has improved sufficiently so the elder no longer needs the services provided by the facility. 3. Should the elder be transferred or discharged for the following reason, the basis for the transfer or discharge must be documented in the elder's clinical record by a physician: a. The health of individual's in the facility would otherwise be endangered..." Review of the residents care plan last revised on 4/22/19 showed no evidence a care plan was developed related to resident behaviors, bathing, discharge planning, toileting, or resident preferences.	F 622		

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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F 656	Continued From page 10 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to develop and implement a comprehensive care plan for 1 of 1 sample residents (#1) with a facility-initiated discharge. The findings were: 1. Review of the quarterly MDS assessment dated 5/27/19 showed resident #1 had a brief interview for mental status score of 12/15 (moderately impaired), verbal behavior symptoms directed at others on 1 to 3 days during the look back period, diagnoses which included diabetes mellitus, malignant neoplasm of the colon, and malignant neoplasm of the uterus. Further review showed the resident required extensive assistance of 1 person for toilet use and dressing and limited assistance of 1 person for bed mobility and transfers. Review of a discharge notice dated 8/17/19 showed the family for the resident was issued a 30-day involuntary discharge notice with a plan to discharge the resident to the family member's home "unless other accommodations are made prior..." The reason for discharge was "continued medical non-compliance" and the family was to contact the facility social worker if they were in need of "in-home services." The following concerns were identified: a. Observation on 7/1/19 at 4:38 PM showed a shahbaz exited the resident's room with soiled linen in her hands and the resident followed in a wheelchair. The resident wheeled him/herself to the dining room table and read papers on the table. The resident returned to his/her room at 5	F 656	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Interdisciplinary team met and reviewed resident #1's care plan and updated it to address elder behaviors and interventions, bathing schedule and preferences, toileting schedule and preferences, and sleep preferences. 2. Staff caring for resident #1 will review the updated care plan and sign an acknowledgement signature page stating that they have reviewed and understand the care plan. How the facility will identify other residents having the potential to be affected by the same deficient practices: 1. The Interdisciplinary team will review and audit each individual care plan of the remaining 47 residents and adjust the care plans accordingly. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	08/16/19

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F 656	Continued From page 11 PM to get his/her glasses. No evidence of odor was noted at that time. Interview with the resident at that time revealed s/he had been at the facility for "a little while" and had to "move out" by July 17th. The resident was unsure why s/he was unable to stay at the facility. b. Review of a social services note dated 6/12/19 and timed 10:22 AM showed "...BIMS score is 12...Elder has become more difficult when it comes to [his/her] cares. Elder does not allow staff to perform [his/her] cares at times and refuses to use the restroom. Elder continues to curse at staff, calls them names and gives them the finger. When attempting to talk to elder about [his/her] behavior [s/he] will curse and yell and tell you to go to hell. IDT [interdisciplinary team] has met with elder and daughter. Elder has agreed to allow [his/her] brief to be changes [sic] every two hours and to take a bath twice a week. Elder s [sic] room has a bad odor due to elder urinating and soiling [him/herself. Elder does have a UTI [urinary tract infection] which is being treated..." c. Review of a social services noted dated 6/17/19 and untimed showed "placed [sic] a call to [family member's name] (elders daughter) informing her of a 30 day discharge. [Family member's name] did not answer the phone. A message was left. Went and talked to [Resident's name]. Explained that a 30 day discharge would be given to [him/her] and one sent to [family member's name]. Elder asked why, I explained it was due to noncompliance with cares. Elder became angry and told me to leave her room. I attempted to let elder know that whatever I can do for [him/her] that I will do. I tried to tell her that my job is to assist [him/her] in an [sic] way I can. [S/he] stopped talking, told me to leave and returned to lying in her bed. DON was present during conversation."	F 656	1. The MDS Coordinator will use the MDS schedule as a cue as to whom to conduct a care plan audit on each month. The Interdisciplinary team will review the applicable care plans during their regularly scheduled monthly team meetings to ensure care plan accuracy and resident function changes and preferences are reflected. Changes and updates to the applicable care plans will be made at that time. 2. The MDS Coordinator will educate staff regarding communicating any immediate changes to the level of care of a resident to the MDS Coordinator so care plans can be adjusted in real time based on the current needs of the resident. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. This plan will be implemented, and the corrective action evaluated for its effectiveness. 2. The plan of correction will be integrated into the Quality Assurance Performance Improvement (QAPI) program and reviewed quarterly for effectiveness and compliance. 3. The Quality Assurance Manager will audit care plans monthly based on the MDS schedule to ensure the accuracy of the care plans reviewed during the monthly team meeting. Responsible: MDS Coordinator	

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F 656	Continued From page 12 d. Review of a social services note dated 6/18/19 and untimed showed "took [sic] the discharge letter to elder. I explained what is [sic] was and asked if there was anything I could do. [S/he] states [s/he] is blind and could not read the letter. I attempted to read it to elder. [S/he] kept interrupting and saying [s/he] was being kicked out because [s/he] did not shower one time. I explained to [him/her] that it was not only that at our last meeting we discussed [his/her] care and [s/he] agreed to toileting every 2 hours and to bathes [sic] 2 times a week. [S/he] stated [s/he] did not agree to this. [S/he] told me to get out of her room. I ask [sic] her if [s/he] could be a little nicer. [S/he] told me [s/he] would be nice and put a foot up my ass. I continued to attempt to explain to elder that my job as a social worker is to assist in any way I could for [him/her] to have a smooth discharge. [S/he] ask [sic] me where [s/he] was going and I again read [him/her] the letter saying we would discharge to [family member's name] home. [S/he] ask [sic] what if [family member's name] did not want [him/her]. Again I tried to explain to [him/her] if [s/he] would just listen and let me assist that I could work with [him/her] and find an appropriate place. [S/he again got angry and told me [s/he] didn't need my help and [s/he] could live in a corner in an alley. I ask [sic] [him/her] to think about letting me help [him/her] and I would check on [him/her] again[sic] [S/he] stated I could help [him/her] by letting [him/her] put a foot up my ass and to leave [his/her] room." e. Review of a social services note dated 6/28/19 and untimed showed "Update on discharge planning: ....6/27 talked to Ombudsman about discharge. Explained the reason for non compliance and behaviors. Elder is refusing bath and refusing toilet. .Explained [sic] that skin was going to breakdown.	F 656		

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F 656	Continued From page 13 [Ombudsman name] stated that elder has a right to refuse. I let her know that elder had refused bathing so elder was only bathing once week [sic] but is now refusing any bath at times and is incontinent and refusing to be changed." f. Review of a progress note dated 6/11/19 and timed 5:18 AM showed "Shahbaz and Nurse assisted elder to restroom; elder was upset, told the shahbaz and nurse that [s/he] wants to 'shoot whoever gets [him/her] up at 4 in the morning'. [sic] Elder then refused to get off the toilet, it took 30 minutes to convince the elder to get off the toilet." g. Review of a progress note dated 6/13/19 and timed 6:10 PM showed "Elder threatened to hit another elder at the dining room table at dinner time. When asked why [s/he] would would make that kind of threat [s/he] stated "why wouldn't I?" When explained that its inappropriate, she gave the Shahbaz the finger." h. Review of a progress note dated 6/14/19 and timed 8:12 AM showed "met with elder who was threatened. [S/he] has no recall of this. Talked to resident [#1] and explained why I was here in the evening. [S/he] stated "I have never hit anyone". [sic] I told [him/her] that [s/he] had threatened another elder. [S/he] insisted [s/he] did not say this. I told [him/her] that when staff talked to [him/her] [s/he] told them [s/he] did. Again elder stated [s/he] did not say this. At this time I am unclear as to if this was said and elder does not remember. Elder has had a UTI and is on medication. No report filed with the state due to one elder not remembering and another elder stating [s/he] did not say this. Also talked to resident who sits by [resident #1] at the table and is able to remember statements. This elder was unable to recall if anything was said..." i. Review of a progress note dated 6/14/19	F 656		

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F 656	Continued From page 14 and timed 12:18 PM showed "Elder was prompted to use the bathroom in the morning and refused. Before lunch elder had rang for assistance. When staff had entered room, there was loose BM on elders bed, floor, wheelchair, shoes, socks, nightgown, and toilet seat. Staff had mentioned again the toileting schedule and that these accidents would be avoided if [s/he] would use the restroom when prompted. Elder got upset and said [s/he] refuses to do a toileting schedule because [s/he] feels [s/he] doesn't get enough sleep. Nurse was notified." j. Review of a progress note dated 6/26/19 and timed 2:37 AM showed "Elder was woke up at 0200 rounds to use the restroom. When told [s/he] had to get up because [his/her] brief was wet, [s/he] started calling staff names such as 'Idiot, stupid' [sic] and saying "Don't speak unless you have something intelligent to say" because [s/he] dribbles and [s/he] stated [his/her] brief is always wet. [S/he] did get up and go to the bathroom, and after nurse visited with [him/her], [s/he] did calm down. When getting back to bed, [s/he] said [his/her] brief was wet, to which this nurse offered to assist [him/her] back to the bathroom. [S/he] just laugher at this response and said [s/he] was going to bed." k. Review of the resident's care plan, last revised on 4/22/19, showed the resident had a cognitive deficit, was at risk for falls, was a diabetic, and needed assistance to maintain his/her current level of function with mobility and ADLs. There was no evidence a care plan was developed related to resident behaviors, bathing, discharge planning, toileting, or resident preferences. l. Interview with the administrator, DON, and social services director on 7/2/19 at 10:37 AM revealed the resident was issued a discharge	F 656		

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F 656	Continued From page 15 notice for "medical non-compliance" as the resident did not "like to bathe" and refused to go to the bathroom or receive incontinence care. They revealed a toileting diary or toileting assessment had not been completed to determine the appropriate toileting plan, they were unsure if the resident had a preferred time of day to shower, the resident had not been evaluated by a physician, and they had no documentation of previously attempted interventions. Further interview confirmed a care plan had not been developed for the resident related to behaviors, hours of sleep, preferences, toileting, or bathing.	F 656		