| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535026 | A. BUILDING _____ B. WING _____ | C 09/25/2020 |

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| **SHERIDAN MANOR** | **1851 BIG HORN AVE SHERIDAN, WY 82801** |

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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys on 8/31/20 through 9/25/20. The survey was prompted by complaint intake WY00003103. | F 000 | | |
| F 660 SS=D | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.<br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.<br>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. | F 660 | | 10/9/20 |

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

Electronically Signed | 10/05/2020

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(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the

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| F 660 | Continued From page 2<br>discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, home health agency staff interview, facility staff interview, and resident representative interview, the facility failed to implement an effective discharge planning process for for 1 of 6 sample residents (#63) reviewed for discharge planning. The findings were:<br><br>Review of the medical record face sheet showed resident #63 was admitted to the facility on 7/24/20 with diagnoses that included colon cancer, lung cancer, alcoholic cirrhosis of the liver, alcoholic liver failure, Type II diabetes with diabetic polyneuropathy, muscle wasting and atrophy, generalized muscle weakness, difficulty walking, and unsteadiness on his/her feet.<br>Review of the resident's care plan, last revised on 8/18/20, identified the resident had impaired cognitive function/dementia, impaired thought processing, and short term memory loss. Review of the 8/14/20 quarterly MDS assessment showed the resident had an indwelling catheter.<br>Review of the physician's orders, last revised 8/23/20, showed the resident was receiving treatment for a wound to the right heel. Orders included "Callous [sic] to right heel: Cleanse with wound cleanser and pat dry. Cover with foam dressing. Every day shift every 2 day(s)" and "Monitor wound on right heel. Every day and night shift." Further review of the orders showed an order to "Provide catheter cleansing and perineal hygiene daily and PRN [as needed] if soiled." The resident received scheduled extended-release opiod and anti-psychotic medications, PRN opiod | F 660 | F660 – Appropriate Discharge<br><br>CORRECTIVE ACTION:<br>This resident is no longer resides in the facility<br><br>INDENTIFICATION OF OTHERS:<br>1.) Residents who discharge home with a wound have the potential to be affected by this deficient practice. No other residents have found to be affected.<br>2.) Residents who discharge home with home health have the potential to be affected by this deficient practice. No other residents have found to be affected.<br><br>SYSTEMIC CHANGE:<br>1.) Education was provided to the wound care nurse by the Director of Nursing on 10.1.20 related to our discharge policy and appropriate education for residents returning home with a wound. The Director of Nursing/designee will audit/oversee all discharges to home to ensure that wound care education is provided during discharge process when appropriate.<br>2.) Education was provided to the social worker by the Director of Nursing on 10.2.20 related to our discharge policy and documentation of home health services. The director of nursing/designee will audit/oversee all discharges to home to ensure that proper documentation of | |

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| F 660 | Continued From page 3<br>and anti-anxiety medications, and non-medication interventions for frequently experienced pain. Monitored side effects of these medications included dizziness, memory problems, loss of balance or coordination, forgetfulness, disorientation/confusion, hypotension, lethargy, decreased energy, and changes in appetite.<br><br>Review of the 8/22/20 Discharge Plan and Summary showed the resident wished to discharge home, and home services needed upon discharge included home health nurse/aide, home health therapy, and other community home services, which consisted of "Meals on wheels, rising Sun therapy, [home health agency] - nursing OT [occupational therapy] services...." Review of the occupational therapy discharge summary dated 8/14/20 showed at the time of discharge, the resident required " ...assistance for the completion of [his/her] daily living activities ... 4WW [four-wheeled walker] for ambulation ... strategies/techniques to orient pt. [patient] to new room/environment and decrease confusion and wandering behaviors ..." Review of the physical therapy (PT) discharge summary dated 8/14/20 showed discharge recommendations included " ...supervision for all transfers and ambulation with 4WW up to 450ft, with use of supplementary O2 [oxygen] to maintain O2 sats [saturation] ..." Review of progress notes specific to discharge and communication to and from the discharging provider dated 8/20/20 showed the resident " ... does currently have a foley catheter in which [s/he] is able to independently empty, but we are unsure if we should DC [discharge] [him/her] home with this. They report that [s/he] was previously straight cathing at home. [S/He] currently does not wear oxygen and does at times sat 88%-90% but is not symptomatic with this." | F 660 | home health referrals is made discharge process when appropriate.<br><br>IDT reviews and participates in all planned discharges to home to ensure proper documentation, education, and interventions are in place.<br><br>MONITORING:<br>The Director of Nursing or designee reviews these audits of all discharges to home monthly and reports any patterns/trends to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue if data is not sufficient. | |

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The note continued " ...We are setting up services to include: meals on wheels, referral to home health, help at home from the senior center ..." A second note indicated " ...Discharge home with home health for OT and nursing care ..." The following concerns were identified:

1. Interview with the resident's representative on 9/21/20 at 12:27 PM revealed the resident was discharged on Saturday, 8/22/20 with " ...a bunch of meds [medications] [s/he] didn't need or take, missing ones [s/he] needed ..." She stated the resident " ...couldn't remember anything ... that s/he had a Foley or to empty it, when to take his/her meds ..." The resident representative stated she was overwhelmed with the situation, and had forgotten about the wound to the resident's right heel until she saw the soiled dressing hanging off the resident's foot. She then realized she had no supplies or directions from the facility on how to care for or manage the wound. She further revealed she called the home health agency to find out when they would be coming to evaluate the resident, and she was informed that the home health agency had communicated to the facility they declined to take the resident on as a client.

2. Interview with the social services director on 8/31/20 at 4:47 PM revealed services for residents are based on need and set up before discharge. She stated that if home health services are needed, she contacts the physician for an order, and then contacts the home health agency. She stated she communicates with a local home health agency " ...pretty regularly and often, since they're the only agency available in this area." Further interview revealed " ...we don't discharge until we have a plan in place, in case of

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delays or changes ... we always work with the family, or care-taker, and resident, depending on cognition status." She further stated she " ... thinks there's a 72-hour window for home health to perform an evaluation, so that's why we don't discharge on the weekends."

3. Review of the progress note dated Saturday, 8/22/20 and timed 10:50 AM showed " ...Resident discharged at 1045 [10:45 AM] this morning ..."

4. Interview on 9/4/20 at 2:21 PM with staff member #1 from the home health agency that received the referral revealed she knew of the resident since they had cared for him/her prior to the resident's most recent hospitalization. She stated s/he was a client from March or April until a July hospitalization, which resulted in his/her discharge from their care. Prior to the hospitalization, the agency was visiting a few times per week, for an hour or two at a time. The staff member stated the certified nurse aide (CNA) performing the visits had issues with the increased level of care the resident needed during those visits. She stated the CNA was struggling to meet all the needs of the client during the sessions, and felt s/he needed a much higher level of care, such as a 24-hr CNA or placement in a nursing home. She further stated it was shortly after the CNA expressed her concerns that the resident was admitted to the hospital. The staff member also stated that she was surprised when she received a referral for the resident, because of the way the resident had regressed while s/he was a client. She stated she communicated these concerns over the phone with social services at the facility, stating the home health agency would be unable to take the resident back on as a client because of the high

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level of care that s/he required.

5. Review of the home health referral provided by the facility showed the referral to the home health agency was hand-dated 8/19/20, however the fax confirmation page showed the fax was sent on 8/21/20 at 4:40 PM (the evening prior to the resident's discharge on 8/22/20 at 10:45 AM).

6. A second interview with the social services director on 9/9/20 at 3:35 PM revealed the resident required services upon discharge, including home health services and Meals on Wheels. She stated the resident didn't qualify for Meals on Wheels due to his/her age, and she had submitted a waiver on the resident's behalf, but " ...it takes weeks for them to determine if you qualify ..." She further revealed she had faxed the referral documents to the home health agency, and spoke to them on the phone about the resident. However, she was unable to provide any documentation of the home health agency's response to the referral.