



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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August 22, 2018

Tory Bosworth, Administrator  
Gateway Transitional Care Center  
527 Memorial Drive  
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **August 9, 2018**, a survey was conducted at Gateway Transitional Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 1, 2018**. Failure to submit an acceptable PoC by **September 1, 2018**, may result in the imposition of penalties by **September 24, 2018**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 13, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 7, 2018**. A change in the seriousness of the deficiencies on **September 23, 2018**,

may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 9, 2018** includes the following:

Denial of payment for new admissions effective **November 9, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 9, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 9, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Tory Bosworth, Administrator  
August 22, 2018  
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **September 1, 2018**. If your request for informal dispute resolution is received after **September 1, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/

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

PRINTED: 09/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE</b> <b>POCATELLO, ID 83201</b>		
(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  The following deficiencies were cited during an on-site complaint survey conducted at the facility from August 8, 2018 to August 9, 2018.  The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Arnold Rosling, RN  Survey Abbreviations: DON = Director of Nursing HHA = Home Health Agency IDT = Interdisciplinary Team PEG = Percutaneous Endoscopic Gastrostomy	F 000			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)  §483.21(c)(1) Discharge Planning Process 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- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (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. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		9/4/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/01/2018

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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F 660	Continued From page 1 developing the discharge plan. (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. (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. (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	F 660			

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F 660	<p>Continued From page 2</p> <p>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.</p> <p>(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 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received an adequate and/or updated discharge plan, timely referrals to home health services, and/or involve residents in the discharge planning process. This was true for 3 of 4 residents (#1, #3 and #4) reviewed for discharge planning. This failure created the potential for harm if residents' various discharge needs were not met. Findings include:</p> <p>The facility's Discharge Planning Process policy, dated January 2018, documented:</p> <p>*Provide and document sufficient preparation to ensure a safe and orderly discharge.</p> <p>*Identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>*Involve the IDT, residents and resident's</p>	F 660	<p>Residents found to be affected by the deficient practice have all since been discharged from the facility</p> <p>All residents planning to discharge have the potential to be affected by the deficient practice. Corrective actions will be to review upcoming/recent (within the last 1-2 weeks) discharges and correct as indicated with the interventions outlined in this plan of correction. Also to ensure the discharge care plan will be updated with any pertinent changes made during family meetings and care conference reviews. Discharge planner or designee will identify home health care agencies that may be involved post facility discharge, initiate contact and establish discharge communications with them prior to facility discharge.</p> <p>Systemic changes that will be made are</p>		

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F 660	<p>Continued From page 3 representative in developing the discharge plan.</p> <p>*Document the evaluation of the resident's discharge needs.</p> <p>1. Resident #3 was admitted to the facility on 4/3/18 with multiple diagnoses, including malignant neoplasm of the esophagus (esophageal cancer), tracheostomy (breathing tube), gastrostomy (feeding tube), and muscle weakness. Resident #3 was discharged from the facility on 5/29/18.</p> <p>Resident #3's discharge area of the care plan, dated 4/10/18, directed staff to:</p> <p>* Establish a pre-discharge plan with the resident.</p> <p>* Evaluate the resident's progress and revise the discharge plan.</p> <p>* Make arrangements with required community resources to support independence post-discharge.</p> <p>* Did not have a preferred home health provider.</p> <p>The discharge area of the care plan did not document Resident #3's needs regarding his tracheostomy and PEG tube.</p> <p>Resident #3's Weekly Skilled Review meeting, dated 5/24/18, documented several staff attended without the resident present. The notes documented Resident #3's progress towards discharge, including his PEG (feeding tube) tube and tracheostomy management status.</p>	F 660	<p>that the policy will be updated to include directions to update discharge care plan as indicated after family meetings and care conference reviews. Policy also to be updated to include identification of home health agencies that may be involved post facility discharge, initiate contact and establish discharge communication with them prior to facility discharge. Measures to be put in place to ensure the deficient practice does not occur are a weekly discharge meeting, with the IDT including but not limited to Social Services, Nursing, Therapy, and discharge planner, wherein discussion will be made referencing the policy to ensure the updated criteria therein is met. All clinical staff in-serviced to the updated policy and procedures.</p> <p>DNS/Designee will monitor the discharge process and updated policies to ensure they are being effectively followed during the weekly discharge meeting 1x/week for 2 weeks, monthly for 1 month and monthly as needed thereafter. Findings will be reported back to the QAPI for continued monitoring of efficiency for the updated discharge process.</p>		

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F 660	<p>Continued From page 4</p> <p>Resident #3's Family Meeting and Social Service notes, dated 5/25/18, documented he and a family member were present. The notes documented Resident #3 wanted to discharge from the facility and agreed to be discharge on 5/29/18, after he was able to independently manage his tracheostomy and PEG tube.</p> <p>Resident #3's Social Service notes, dated 5/29/18, documented, "Resident approached discharge planner multiple times throughout the day to discuss discharge...Discharge orders were obtained and reviewed with resident...referral was sent to [Local Home Health Agency]. Discharge planner stated it could take a few days for services to begin but resident could expedite process by contacting the home health agency and setting up an appointment that worked for both the home health and resident."</p> <p>A facility's Fax status page, dated 5/30/18 at 8:57 AM, documented Resident #3's medical information was sent to the HHA.</p> <p>On 8/9/18 at 11:05 AM, the Social Worker said Resident #3's discharge portion of the care plan did not include updates discussed in the Weekly Skilled Review meeting or in the Family Meeting, did not document the resident's tracheostomy and PEG tube needs at discharge, and did not document which HHA the resident had chosen. The Social Worker said she had made a verbal referral to the HHA and did not know why the resident's medical information was sent to the HHA the day after he was discharged. The Social Worker said she had contacted the HHA on 6/1/18 and had been informed that Resident #3</p>	F 660			

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F 660	<p>Continued From page 5</p> <p>had been seen for the first time by the HHA that day. Resident #3's first visit from the HHA was completed 3 days after his discharge from the facility on 5/29/18.</p> <p>2. The Diagnosis Section of the electronic medical record identified Resident #1 was admitted on 5/23/18 with diagnoses of unspecified fracture of the upper end of the right humerus (upper arm bone) and scapula (shoulder blade) and post joint replacement and falls.</p> <p>The Discharge Plan dated 5/23/18, located in the electronic medical record and attached to the care plan documented: "Resident #1 anticipates returning to (name) ALF (Assisted Living Facility) in (town)" The discharge plan interventions included:</p> <ul style="list-style-type: none"> <li>* Encourage to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress.</li> <li>* Establish a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan.</li> <li>* Evaluate and discuss with resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitation, risks, benefits and need for maximum independence.</li> <li>* Make arrangements with required community resources to support independence post-discharge. (Resident #1) prefers (name) Home Health.</li> </ul>	F 660			

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F 660	<p>Continued From page 6</p> <p>* Provide a list of any upcoming appointments post discharge to (Resident #1) and (name) assisted living facility.</p> <p>On 6/4/18 at 2:00 PM, the Discharge Coordinator documented a family meeting was held that included the resident, resident's son, Discharge Coordinator, business office manager, therapy and nursing. The meeting addressed Resident #1's need for oxygen, walker, wheelchair, and power scooter.</p> <p>After the family meeting, Resident #1's 5/23/18 Discharge Plan was not updated to reflect his need for oxygen, walker, wheelchair, and power scooter after discharge.</p> <p>Resident #1's medical record, electronic and paper versions, was reviewed. Resident #1's medical record did not include documentation of an additional meeting, after 6/4/18 with him or his family about his discharge and discharge needs.</p> <p>On 8/9/18 at 11:50 AM, the Discharge Coordinator confirmed Resident #1's discharge plan was not updated with his current discharge information.</p> <p>3. The Diagnosis Section of the electronic medical record identified Resident #4 was admitted to the facility 5/4/18 with diagnoses of left artificial knee joint and after care joint replacement surgery. The documentation further identified Resident #4 was discharged on 6/21/18.</p> <p>Resident #4's Discharge Plan, dated 5/9/18,</p>	F 660			

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F 660	<p>Continued From page 7</p> <p>located in the electronic medical record and attached to the residents' care plan documented: "(Resident #4) lives alone in a 2-level home with 4 - 5 steps to enter. There are 11 steps to the basement." The discharge plan interventions included:</p> <ul style="list-style-type: none"> <li>* Encourage to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress.</li> <li>* Establish a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan.</li> <li>* Evaluate and discuss with resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitation, risks, benefits and need for maximum independence.</li> <li>* Make arrangements with required community resources to support independence post-discharge. (Resident #4) prefers (name) Home Health.</li> <li>* Provide a list of any upcoming appointments post discharge.</li> </ul> <p>On 6/15/18 at 1:00 PM, the Discharge Coordinator documented a family meeting was held that included Resident #4, her brother, Discharge Coordinator, social service, therapy and nursing staff. The meeting addressed Resident #4's need for nutrition assistance, such as Meals-on-Wheels after discharge. After the family meeting Resident #4's 5/9/18 Discharge Plan was not updated to reflect her need for</p>	F 660			

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F 660	Continued From page 8 nutritional assistance post-discharge.  Resident #4's medical record, electronic and paper versions, was reviewed and did not reflect an additional meeting with her or her family about her discharge.  On 8/9/18 at 11:50 AM, the Discharge Coordinator confirmed Resident #4's Discharge Plan was not updated with current discharge information.	F 660			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)  §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661		9/4/18	

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE</b> <b>POCATELLO, ID 83201</b>		
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F 661	<p>Continued From page 9</p> <p>the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' records contained a complete discharge summary. This was true for 2 of 2 residents (#3 and #4) reviewed who were discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation related to residents' discharge. Findings include:</p> <p>The facility's Discharge Summary policy, dated January 2018, documented a recapitulation of residents stay included diagnoses, course of illness/treatment or therapy, pertinent lab, radiology, and consultation results. The policy did not address the need to include other care areas listed on the resident's most recent comprehensive assessment.</p> <p>1. Resident #3 was admitted to the facility on 4/3/18 with multiple diagnoses, including malignant neoplasm of the esophagus (esophageal cancer), tracheostomy (breathing tube), gastrostomy (feeding tube), and muscle weakness. Resident #3 was discharged from the facility on 5/29/18.</p> <p>Resident #3's Weekly Skilled Review meeting, dated 5/24/18, documented several staff attended without the resident present. The notes documented Resident #3's progress towards discharge, including his PEG tube and</p>	F 661	<p>The residents identified to have been affected by the deficient practice have been discharged from the facility.</p> <p>Other residents that have the potential to be affected by the deficient practice are residents planning to discharge from the facility. Corrective actions include reviewing upcoming/recent discharges (within the last 1-2 weeks) and discharge summaries and correct as indicated with the interventions outlined in this plan of correction, incorporating into the discharge summary services of the residents preferred home health agency, other care areas listed on the most recent comprehensive assessment, and required information as identified in the state and federal guidelines in F661 section 483.21 including but not limited to:</p> <ol style="list-style-type: none"> <li>1. Identification and demographic information</li> <li>2. Customary routine</li> <li>3. Cognitive patterns</li> <li>4. Communication</li> <li>5. Vision</li> <li>6. Mood and behavior patterns</li> <li>7. Psychosocial well-being</li> <li>8. Physical functioning and structural problems</li> <li>9. Continence</li> </ol>		

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F 661	<p>Continued From page 10 tracheostomy management status.</p> <p>Resident #3's Family Meeting and Social Service notes, dated 5/25/18, documented he and a family member were present. The notes documented Resident #3 wanted to discharge from the facility and agreed to be discharge on 5/29/18, after he was able to independently manage his tracheostomy and PEG tube.</p> <p>Resident #3's Social Service notes, dated 5/29/18, documented, "Resident approached discharge planner multiple times throughout the day to discuss discharge...Discharge orders were obtained and reviewed with resident...referral was sent to [Local Home Health Agency]. Discharge planner stated it could take a few days for services to begin but resident could expedite process by contacting the home health agency and setting up an appointment that worked for both the home health and resident."</p> <p>A facility's Fax status page, dated 5/30/18 at 8:57 AM, documented Resident #3's medical information was sent to the HHA.</p> <p>Resident #3's Discharge Summary, dated 5/29/18, documented he was admitted to the facility with a tracheostomy and a feeding tube. The summary of stay included Resident #1 was assisted with therapies related to strengthening, gait/balance and speech, pain management, medication management and assistance with his activity of daily living. The summary did not document Resident #3 was discharged with the services of an HHA and his management status regarding his tracheostomy and PEG tube.</p>	F 661	<p>10. Disease diagnosis and health conditions</p> <p>11. Dental and nutritional status</p> <p>12. Skin condition</p> <p>13. Activity pursuit</p> <p>14. Medications</p> <p>15. Special treatments and procedures</p> <p>16. Most recent discharge care plan</p> <p>17. Documentation of summary information</p> <p>Systemic changes and measures to be taken to ensure the deficient practice does not happen again are to update the policy to include in the discharge summary services of the residents preferred home health agency, other care areas listed on the most recent comprehensive assessment, and required information as identified in the state and federal guidelines in F661 section 483.21 including but not limited to:</p> <p>18. Identification and demographic information</p> <p>19. Customary routine</p> <p>20. Cognitive patterns</p> <p>21. Communication</p> <p>22. Vision</p> <p>23. Mood and behavior patterns</p> <p>24. Psychosocial well-being</p> <p>25. Physical functioning and structural problems</p> <p>26. Continence</p> <p>27. Disease diagnosis and health conditions</p> <p>28. Dental and nutritional status</p> <p>29. Skin condition</p>		

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F 661	<p>Continued From page 11</p> <p>On 8/9/18 at 11:05 AM, the Social Worker and the Discharge Coordinator said nursing completed the discharge summaries and were not aware of what was required on the discharge summary. The Social Worker said the summary did not include documentation Resident #1 went home with services from an HHA.</p> <p>On 8/9/18 at 12:10 PM, the DON said Resident #3's discharge summary did not include documentation he was discharged with HHA services and the DON was not aware of what was required on the discharge summary.</p> <p>2. The Diagnosis section of the electronic medical record identified Resident #4 was admitted to the facility 5/4/18 with diagnoses including left artificial knee joint and after care joint replacement surgery. The documentation further identified Resident #4 was discharged 6/21/18.</p> <p>Resident #4 had a paper medical record in addition to an electronic medical record.</p> <p>Resident #4's Discharge Summary, which was handwritten by a Licensed Nurse on 6/21/18 documented: "Pt (patient) admitted to GTC (Gateway Transitional Care) for left knee after surgery care. Pt received assistance (with) ADLs (activity of daily living), medication management, Labs (bloodwork) and Vitals (vital signs), PT/OT/SP (Physical, Occupational, Speech Therapy) for strength training balance and gait training, cognition training." No additional discharge summary information was found in the medical record.</p>	F 661	<p>30. Activity pursuit</p> <p>31. Medications</p> <p>32. Special treatments and procedures</p> <p>33. Most recent discharge care plan</p> <p>34. Documentation of summary information</p> <p>Other systemic changes and measures to be taken will be to have a weekly discharge meeting with the IDT including but not limited to Social Services, Nursing, Therapy, and discharge planner, wherein discussion will be made referencing the policy to ensure the updated criteria therein is met. All clinical staff in-serviced to the updated policy and procedures.</p> <p>DNS/Designee will monitor the discharge process and updated policies to ensure they are being effectively followed during the weekly discharge meeting 1x/week for 2 weeks; monthly for 1 month and monthly as needed thereafter. Findings will be reported back to QAPI for continued monitoring of efficiency for the updated discharge process.</p>		

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F 661	<p>Continued From page 12</p> <p>The Discharge Summary did not include the following required information:</p> <ul style="list-style-type: none"> <li>* Identification and demographic information</li> <li>* Customary routine</li> <li>* Cognitive patterns</li> <li>* Communication</li> <li>* Vision</li> <li>* Mood and Behavior patterns</li> <li>* Psychosocial well-being</li> <li>* Physical functioning and structural problems</li> <li>* Continence</li> <li>* Disease diagnoses and health conditions</li> <li>* Dental and nutritional status</li> <li>* Skin condition</li> <li>* Activity pursuit</li> <li>* Medications</li> <li>* Special treatments and procedures</li> <li>* Most recent discharge care plan</li> <li>* Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS.</li> <li>* Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.</li> </ul> <p>On 8/9/18 at 11:05 AM, the Discharge Coordinator was interviewed about the contents of the Discharge Summary. The Discharge Coordinator stated she was not aware of the federal discharge summary requirements.</p>	F 661			