STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495331	A. BUILDING _____ B. WING _____	C 01/14/2021

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GRAYSON REHABILITATION AND HEALTH CARE CENTER	400 SOUTH INDEPENDENCE AVENUE INDEPENDENCE, VA 24348

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 01/12/21 through 01/14/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Complaint were investiaged during the survey. The census in this 120 certified bed facility was 85 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents # 3and #4) and 2 closed record reviews (Residents #1 and #2).	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. Nonpayment applies if the resident does not submit the necessary paperwork for third party	F 622		2/25/21

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

Electronically Signed | 02/17/2021

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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 facility to meet the need(s).
(ii) The documentation required by paragraph (c)

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F 622	Continued From page 2 (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 staff interview, clinical record review, facility document review and in the course of a complaint investigation the facility failed to allow a resident to return to the facility for 1 of 4 residents, Resident #1 The findings included: For Resident #1, the facility failed to allow the resident to return after a hospital visit. Resident #1's face sheet listed diagnoses of but not limited to chronic obstructive pulmonary disease, hypertension, history of pulmonary embolism, alcohol dependence in remission,	F 622	1. Resident #1 currently does not reside in center of Grayson Rehabilitation and Health Care Center. 2. A quality monitoring review was completed on 2/15/21 of residents who have discharged in the previous 3 months to ensure the discharge was appropriate and the resident was allowed to remain in the facility unless criteria was met for facility-initiated transfer per facility policy. The quality review was completed by the ED/designee. A quality review was completed on	

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F 622	Continued From page 3 anxiety, and major depressive disorder. Resident #1's admission MDS (minimum data set) with an ARD (assessment reference date) of 07/30/2020 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, cognitive patterns. Resident #1's clinical record was reviewed and contained an admission assessment dated 07/23/2020, which read in part "Section D: Mood/Behaviors/Psychosocial: Mood: Pleasant Behaviors: No obvious problems Section N: Safety: Elopement Risk Evaluation: Based on potential risk factors above, resident is determined to be AT RISK for elopement: NO". Resident #1's clinical record also contained an admission social services evaluation dated 07/30/2020, which read in part "Resident anticipated discharge plan: LTC (long-term care) Resident's overall discharge goal: Expects to remain in this facility". Resident #1's clinical record contained a form, which read in part "PLEASE POST ON CHART. THIS PERSON HAS A COURT-APPOINTED GUARDIAN" and "In the event of an emergency, particularly a medical or mental health emergency, involving the ... (name omitted) Program's client, ... (Resident #1), you are required to contact the Primary Case Manager immediately." The resident's clinical record also contained a form, which read in part "ORDER APPOINTING GUARDIAN. IN CONSIDERATION WHEREOF, the Court makes the following findings, supported by clear and convincing evidence: ... It is therefore ADJUDGED, ORDERED, and DECREED: 3. That the incapacities of the Respondent (Resident #1) are	F 622	2/15/21 for residents who currently have discharge plans to ensure the discharge plan meets requirements in F622. The quality review was completed by the ED/designee. 3. The Executive Director/designee initiated re- education to the Interdisciplinary team (Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager , Social Worker and Admission Coordinator) and direct care licensed nurses and will be completed by 2/25/21. The education provided included the facility policy and procedure regarding transfer and discharge requirements. A quality review will be completed by the ED/designee weekly for three months to ensure residents who were discharged, or sent to the emergency department were allowed to return to the facility using the policy and procedure for transfer and discharge requirements. Facility staff identified as not receiving the education will receive prior to working their next schedule shift. 4. The facility Executive Director will report the finding of the quality monitoring reviews to Quality Assurance Performance Improvement Committee monthly for three months. The committee will review the findings and determine if changes are necessary in plan of correction to sustain and maintain substantial compliance. 5. Date of Compliance February 25, 2021	

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total and perpetual, and that the Respondent is relieved of all authority and power to manage and perform legal acts in respect to his person, such power and authority being vested in the guardian."

Resident #1's clinical record contained nurse's progress notes, which read in part "9/28/2020 10:20 Social Services Progress Note. SW (social worker) notified Guardian of resident's determination to go to hospital. She said send him if he feels he need to go.", "9/28/2020 10:21 Nursing Progress Note. Resident outside smoking with CNA (certified nursing assistant) supervision. Stated he needed to leave and go to the hospital. CNA, administrator and DON (director of nursing) attempted to talk resident into coming back inside the building so a nurse could assess him and resident refused. Resident stated he was leaving and was going to call a taxi to come get him and take him to the hospital. Explained that the nurse could assess him and he could go to the hospital via ambulance. Resident refused to come back inside the building and started walking away. Explained that he was leaving against medical advice and resident continued walking off the premises stating he did not want to stay here and would walk to the hospital. 911 called and resident was picked up by EMT's (emergency medical technician) and transported to the hospital. MD notified.", "9/28/2020 14:29 Nursing Progress Note. ER discharged resident. Transport arranged for resident to return to this facility. Driver called facility and reported that while transporting resident back to this facility resident unlocked van door, took seatbelt off and jumped out of van at stop sign. Resident ran away and police were notified to look for resident.", and "9/29/2020 8:21

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Social Services Progress Note. Resident left facility on 09/28/2020-alert & oriented to self, stated he was going to the hospital in ... (omitted)-ambulatory. Staff attempted to reason with resident for him to come back inside and be assessed. He declined. Law Enforcement notified. He was evaluated ER. ER notified facility he was ready to return to facility. Facility staff member went to pick him up to return to facility. Resident exited the van and left per report of staff member. Police notified. D/C (discharged) from facility. APS (adult protective services) aware. Guardian aware."

Surveyor spoke with DON on 01/12/21 at approximately 9:30 am. DON stated that resident was outside smoking with staff, when he stated he was leaving and began walking toward road. DON stated that staff attempted to talk resident into coming back, but he said he did not want to be at the facility. DON stated that resident began walking up the road, and that staff stayed with him. DON stated that EMS was called, and picked resident up and transported him to the hospital. DON stated that hospital called the facility and said resident was being discharged. Facility agreed to pick resident up from hospital. DON stated that when transport staff arrived at hospital, resident was again saying that he did not want to be at facility, and did not want to return. DON stated that transport staff reported that resident got out of vehicle at stop sign and ran. Transport staff returned to hospital and notified facility and police. Surveyor asked DON why the facility did not allow resident to return after he was located by the police and DON stated, "We considered it an AMA (against medical advice)."

Surveyor spoke with the facility administrator on

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01/12/21 at approximately 10:10 am. Administrator stated that there was not talking resident into coming back to facility and that staff had tried to talk to him for approximately 45 minutes outside facility before he left the premises. Administrator stated that when the resident left the facility, a facility staff went with him for safety purposes. Administrator stated that the police were notified and EMS picked the resident up and transported to the hospital. Administrator stated that they did not consider this as an elopement, but as a leaving AMA.

Surveyor spoke with Resident #1's guardian on 01/12/21 at approximately 12:00 pm. Guardian stated that resident has a diagnosis of alcohol dementia. Guardian stated that resident had been doing well at the facility and had not had any problems. Guardian stated that resident had a history of elopement. Guardian stated that on 09/28/2020, the facility social worker had notified them that resident was requesting to go to the hospital and was attempting to leave the facility. Guardian stated that they told the social worker to go ahead and send resident to hospital to be evaluated due to his history and COVID positive status. Guardian stated that resident was seen at the ER and cleared to go back to facility. Guardian stated that while resident was being transported back to the facility, he jumped out of facility van and got onto a local transit bus. Guardian stated that police located the resident and returned him to the hospital and facility was notified, but refused to take resident back. Guardian stated that resident "was literally stranded at the ER for close to 2 weeks, because no other facility would take him, because he was COVID positive". Surveyor asked the guardian if they wanted resident returned to the facility, and

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guardian stated that they did. Surveyor asked guardian if the facility had asked them to sign an AMA form, and guardian stated they had not.

Surveyor spoke with facility transport staff on 01/3/21 at approximately 10:05 am. Transport staff stated that resident had ran from facility earlier in the day and that either EMS or police had picked him up and taken him to the hospital. Transport staff stated that he had been asked to go pick resident up from hospital. Transport stated that when he arrived at the hospital, Resident #1 was "giving the staff a fit", and stating that he did not want to return to the facility. Transport staff stated that hospital staff talked Resident #1 into returning to the facility, and walked resident to the van and he got in. Transport staff stated they assisted resident with seatbelt and locked the van door. Transport staff stated he noticed the resident messing with the door lock and when they stopped at a stop sign, resident jumped out of van and ran "off through the neighborhood". Transport driver stated that they immediately turned around and went back to hospital and notified facility and hospital staff notified the police. Surveyor asked the transport driver if they saw Resident #1 board a transit bus, and transport driver said they did not.

Surveyor requested the facility policy on discharges and was given a policy entitled, "Transfer/Discharge Notification & Right to Appeal". This policy read in part, "PROCEDURE: Transfer/Discharge Requirements: The center must permit each resident to remain in the center, and not transfer or discharge the resident from the center unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the

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F 622	Continued From page 8 center;...Documentation: When the center transfers or discharges resident under any circumstance listed above the facility will 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. Documentation in the medical record to include: The basis for the transfer; In the case of inability to meet resident needs (as per (a) above); The specific resident's need that cannot be met, The facilities attempts to meet the resident needs, And the service available at the receiving facility to meet those needs. The documentation must be made by: The resident's physician when the transfer or discharge is necessary due to: The resident's welfare and the resident's needs cannot be met in the center". The concern of the facility not allowing the resident to return to the facility was discussed with the administrative team (administrator, DON) via telephone on 01/14/21 at approximately 3:15 pm. No further information was provided prior to exit. This is a complaint deficiency.	F 622		