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A 000	INITIAL COMMENTS A complaint survey, prompted by CO#23419 and CO#23595 was completed on 5/29/19. Three deficiencies were cited, including one Condition level deficiency.	A 000		
A 799	§482.43 Discharge Planning DISCHARGE PLANNING CFR(s): 482.43 The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on the manner and degree of the standard level deficiency referenced to the Condition, it was determined the Condition of Participation §482.43, DISCHARGE PLANNING, was out of compliance. A-806 - (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient ' s behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. Based on interviews and document review the facility failed to ensure patient discharge plans were re-evaluated to	A 799		

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

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A 799	Continued From page 1 meet the needs of the patient when concerns were identified prior to the patient being discharged. Additionally, the facility failed to verify the availability of services prior to discharge. This failure occurred in 3 of 14 discharged patients (Patients #10, #19, and #20). This failure resulted in Patient #10, who had admitted to sexual perpetration of her younger sibling, to be discharged home with the same sibling in the home, with no education to the patient or family on how to address concerns and ensure all family members were safe. Furthermore, this resulted in patients being discharged to locations which were unable to meet the patient's needs. A- 811 - The hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf. Based on interviews and document reviews the facility failed to involve and notify the patient's legal representative with the final discharge plan and placement in 1 of 7 patients who had a guardian involved in their care (Patient #4).	A 799		
A 806	DISCHARGE PLANNING NEEDS ASSESSMENT CFR(s): 482.43(b)(1), (3), (4) (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the	A 806		

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A 806	Continued From page 2 availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. This STANDARD is not met as evidenced by: Based on interviews and document review the facility failed to ensure patient discharge plans were re-evaluated to meet the needs of the patient when concerns were identified prior to the patient being discharged. Additionally, the facility failed to verify the availability of services prior to discharge. This failure occurred in 3 of 14 discharged patients (Patients #10, #19, and #20). This failure resulted in Patient #10, who had admitted to sexual perpetration of her younger sibling, to be discharged home with the same sibling in the home, with no education to the patient or family on how to address concerns and ensure all family members were safe. Furthermore, this resulted in patients being discharged to locations which were unable to meet the patient's needs. Finding include: Facility policy: According to the Discharge and Continuing Care Planning policy, discharge planning is an organized, coordinated process with multidisciplinary team, patient and family input which identifies the patient's needs after discharge, delineates plans to meet these needs and teaches the patient and family how to	A 806		

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implement the plans. The therapist is responsible for coordinating the discharge plan. Teaching the patient problem solving is a critical part of helping the patient process discharge. Family teaching and involvement are also important as family support will make a big difference after discharge. The family needs to know about the illness, treatment and accomplishments. They also must be told what changes to look for and who to call for help. When making plans, the staff should consider the patient's living situation. If at any time, a member of the treatment team believes a scheduled discharge is unsafe, they will communicate concerns with the treatment team.

According to the policy, Aftercare Compliance with Discharge Plan, the therapist/case manager addresses discharge planning with the family, when appropriate, and the patient during the family therapy sessions and conferences on an ongoing basis. This is documented through the course of treatment in the medical record and case management notes. The therapist/case manager ensure the patient/caregiver and/or family understands the discharge continuing care plan. The therapist/case manager coordinates discharge planning with the community agency to which the patient is referred. The purpose was to ensure all patients/caregivers receive communication regarding their discharge continuing care plan and follow-up on the patients compliance with the plan. The facility ensures each patient/caregiver and as appropriate, family has participated in, and understand their discharge plan and instructions.

According to the policy, Patient Family Education,

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information about any discharge instructions given to the patient and/or his/her significant other is provided to the individual or organization responsible for the continuing care of the patient. The purpose is to ensure patients and families will receive the necessary education as specific needs are identified.

According to the policy, Discharge Planning, discharge planning occurs for all patients and includes various outside service agencies to help the client to continue to improve or maintain his or her mental health status. Consideration should also be given to enlist the social support system of choice to facilitate a safe and effective discharge plan.

According to the policy, Case Management/Discharge Planning protocol, the discharge criteria includes the patient is not a danger to self or others. The patient has a completed aftercare and safety plan with provision for continued contact and support.

According to the policy, Treatment Plan Acute Inpatient, each patient admitted to the psychiatric unit shall have an individualized treatment plan which is based on interdisciplinary clinical assessments. Patients are involved in the treatment planning process and sign their treatment plans. In order to determine the effectiveness of the Master Treatment Plan, weekly reviews are done by the interdisciplinary team and major areas to address will be discharge planning considerations.

A. The facility failed to re-evaluate Patient #10's discharge plan after the patient and her family

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A 806	Continued From page 5 voiced concerns and felt unsafe with the discharge plan. 1. Review of Patient #10's medical record revealed the patient was admitted on 1/31/19 at 6:43 p.m. due to suicidal ideation and sexually inappropriate behavior. A Comprehensive Psychosocial Evaluation, completed on admission, documented the patient currently lived with her step-mother, father and younger siblings. An Initial Psychiatric Evaluation, dated 2/1/19 at 8:35 a.m. and completed by the nurse practitioner (Provider #6), documented Patient #10 had the potential to harm others related to the patient's history of pushing her sibling, causing him to almost fall off of a railing, and she could not be alone with animals due to harming them, with reportedly no remorse. The provider documented Patient #10's current symptoms as acting out sexually, to include watching pornographic material. a. Review of Patient #10's medical record showed documentation by multiple staff in which Patient #10 and her family felt unsafe and disagreed with the discharge plan put in place by the facility. Examples included: i. According to the Therapy Services Progress Note, dated 2/4/19 at 2:18 p.m., Patient #10's parents were not fully prepared to have the patient discharged tomorrow (2/5/19) and felt the patient was "playing a game." Therapist #3 documented she advised the family to start thinking about discharge and discussed outpatient therapy plans. According to the note,	A 806		

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Patient #10's step-mother stated the patient had received outpatient therapy but "it was not effective, so it needs to be more than an outpatient therapist." Therapist #3 documented the plan for Patient #10 was to continue with treatment goals and discharge planning.

ii. The next day, on 2/5/19 at 8:49 a.m., Therapist #3 documented in the therapy progress note, she spoke with the patient's step-mother regarding discharge "today." The step-mother "expressed frustration" and explained she and Patient #10's father did not agree with the plan "due to the patient's long history of aggressive and hostile behaviors." Therapist #3 documented she informed the family the patient was not an imminent risk to herself or others and a "suggestion was for the family to begin looking for long-term residential facilities if they did not want the patient home or felt she was unsafe."

On 2/5/19 at 10:20 a.m., Therapist #3 documented, in the communication log, she had received a phone call from the outpatient therapy services who stated they had contacted Patient #10's father who was irate and refused to set up outpatient services.

At 12:40 p.m. on 2/5/19, Therapist #3 documented a subsequent conversation with Patient #10's father, in a therapy progress note. According to the documentation, Patient #10's father was upset the patient was being discharged that day due to the patient's history and her indication of harm to herself and others. It was further documented Patient #10's father did not feel safe with Patient #10 around her toddler brother. Therapist #3 documented if the

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patient was deemed safe then the patient was expected to return back home and pursue outpatient therapy.

Therapist #3 documented she advised Patient #10's father if the family it felt unsafe for Patient #10 to return to their home, a child protective services (CPS) and/or department of human services (DHS) report could be made by the family or the therapist to activate services related to group home or long-term residential. Therapist #3 documented she advised, Patient #10's father, the facility was not a placement service and she would make a report to CPS/DHS. She then documented the family was not receptive to the information/suggestions. The plan was to continue with treatment goals, discharge planning and discuss with staff tomorrow.

iii. On 2/6/19 at 12:29 p.m. in a Psychiatric Progress Note, Physician #15 documented the patient reported her parents don't want her to return home. The physician documented at the time of admission the parent's reported she had attempted to push her younger brother off the balcony. Physician #15 noted per therapy, the patient's father and step-mother do not want the patient to return home. The therapist filed a report with DHS due to abandonment. The staff attempted to schedule a family meeting but the parents refused to attend.

iv. On 2/7/19 at 12:58 p.m., Therapist #3 documented, in the therapy progress note, a family session was conducted via the phone. Therapist #3 documented Patient #10's step-mother's concerns included safety for not only the patient but for "siblings, family and

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animals in the home," the patient's violent outbursts and her being unpredictable and impulsive. The therapist documented Patient #10's step-mother expressed concern regarding the patient's inappropriate interactions with her younger brother and stated Patient #10 had inappropriately touched her brother and watched sexually explicit content.

At 1:04 p.m., Therapist #3 documented in the therapy progress note an individual therapy session was conducted with Patient #10. According to the note Patient #10 admitted to touching her three year old brother inappropriately and when asked to elaborate, she stated, "I can't remember, but he asked me to touch him one time and I touched his chest." Patient #10 then stated, "I touched his crotch once or twice." Patient admitted to experiencing "happiness" from hurting others and "sometimes" feels remorse. Patient admitted to watching sexually explicit content since the fifth grade, approximately two years ago.

Therapist #3 documented when asked if she felt safe to return home, she stated, "I don't know anymore" then stated "I'm not ready to go home, I don't want to hurt my brother or be inappropriate with him." Therapist #3 documented the plan was to continue treatment goals and discharge planning.

v. On 2/8/19 at 11:26 a.m., in a psychiatric note, Provider #6 documented per therapy the parents learned Patient #10 "sexually perpetrated her brother. Parents do not want her home. DHS is now involved."

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vi. On 2/10/19, Patient #10's discharge date, at 9:04 a.m., Therapist #3 documented in the therapy progress note, she contacted Patient #10's father as he had reached out to the nurse with concerns which needed to be addressed. Therapist #3 documented the father wanted to know what was going on as it was "looking like we need to come and get her still." Therapist #3 advised the father that was "looking like the case". The father then requested to speak with the attending physician as he had been "wanting to since last week." Therapist #3 advised the father the physician had reached out to him last week. The father again requested to speak with a physician. Therapist #3 advised the father it would not happen until tomorrow, even though the patient was scheduled for discharge before tomorrow.

On 2/10/19 at 9:18 a.m., the registered nurse (RN #4) documented she spoke with Patient #10's stepmother who reported Therapist #3 hung up on the patient's father and they had unanswered questions. RN #4 documented the questions the family had were: How did the rest of the family session go? Had anyone heard back from DHS? What was said to DHS to get things moving? Could they get a case number for the parents to talk to DHS?

According to the discharge continuation plan signed by RN #4 and Patient #10's father on 2/10/19, there was no indication Patient #10's stepmother's questions had been addressed and answered prior to discharge or indication the father was able to speak with a physician.

Furthermore, on review of the medical record

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there was no documentation how staff ensured Patient #10's post-discharge needs had been assessed, addressed, how staff adjusted the treatment plan, and delineated a plan to meet the discharge needs of Patient #10 after new information was presented on 2/7/19. There was also no documentation the family received any education on how to address Patient #10's sexual perpetration of her younger brother to ensure all family members were safe. This was in contrast to the policy, discharge and continuing care planning which read, the discharge planning process was coordinated with patient and family input, to identify the patient's needs after discharge, delineate plans to meet those needs, and teach the patient and family how to implement the plan.

vii. On 2/10/19 at 2:57 p.m., Therapist #3 documented in the therapy discharge note the discharge living arrangements for Patient #10 were to return to prior living arrangements with father, stepmother and siblings. There was no documentation, outside of making a phone call to DHS, how facility staff addressed Patient #10's statement made on 2/7/19 in which she stated, "I'm not ready to go home, I don't want to hurt my brother or be inappropriate with him." This was in contrast to facility policy which stated patient discharge criteria included the patient not being a danger to self or others.

b. On 5/24/19 at 6:34 a.m., an interview was conducted with RN #4, who discharged Patient #10 on 2/10/19. RN #4 stated her role in patient discharge was to make sure patients had not gotten worse since arrival, to chart whether the patient was denying or having suicidal or

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homicidal ideation (SI/HI) and notify the physician if the patient was. RN #4 stated if a patient said something alarming, such as a patient planned to hang themselves at home or the patient didn't have electricity at home the physician, the therapist, and the house supervisor would be notified prior to discharge.

RN #4 stated the therapists were in charge of finding patient placement and to figure out the plan for discharge; "therapy ultimately orchestrates what happens with discharge." RN #4 stated if the patient told me they were not having thoughts of hurting themselves, were calm and cooperative and denying SI/HI then we would discharge the patient.

RN #4 then reviewed Patient #10's medical record. On review RN #4 stated she was unaware Patient #10 had disclosed she had sexually abused her younger sibling on 2/7/19, prior to discharging the patient.

c. On 5/24/19 at 12:33 p.m. an interview was conducted with Therapist #3, who stated she had been in charge of Patient #10's discharge on 2/10/19. Therapist #3 reviewed Patient #10's medical record. Therapist #3 stated at the time she took care of Patient #10, she had not been properly trained or received the education she needed to discharge patients. Therapist #3 stated her attitude and main focus was to report the sexual abuse and get it documented; now that time had passed, she stated she was seeing the safety issues involved; it wasn't a safe discharge, not for the patient or her brother.

On review of Patient #10's medical record,

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Therapist #3 stated there had been no follow up by the facility with Patient #10 or her family after Patient #10 admitted to sexual abuse of her younger brother prior to her discharge two days later. She then stated Patient #10 should not have been discharged; she should not have been allowed to be around her younger brother as the patient was at risk of sexual abusing her little brother again. Therapist #3 further stated the nursing staff who had reviewed Patient #10's discharge continuation plan with the patient and her father, had not been made aware of the patient's sexual perpetration on her brother.

Therapist #3 stated the facility should have looked at alternative plans for Patient #10 and confirmed they had not.

d. On 5/28/19 at 4:43 p.m., an interview was conducted with Medical Director (Physician) #8. Physician #8 stated he had been in his role at the facility for one year. Physician #8 stated there had been no changes in the discharge process since he became the medical director.

Physician #8 reviewed Patient #10's medical record and stated he was unaware of the patient's case. On review of the therapy progress note, documented on 2/7/19 at 1:04 p.m., the physician stated this should have changed Patient #10's discharge. Physician #8 stated he would have wanted to get Child Protective Services' perspective and additional information to determine if it was safe to send the patient home with other children in the home. Physician #8 confirmed there was no documentation of how the facility changed Patient #10's discharge plan after 2/7/19. Physician #8 stated that the parents

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had to ensure the safety of everyone in the household, including Patient #10.

On continued review of Patient #10's medical record, Physician #8 stated he was getting more "confused" the more he read and stated "I'm not sure what happened and why it's not documented."

Physician #8 stated Patient #10 was at "risk of her perpetrating again, abusing her little brother." Physician #8 then stated Patient #10's parents had appropriate questions which needed to be answered and stated on review of the medical record, the questions were not answered by staff.

On 5/29/19 at 5:56 p.m., Physician #8 stated after a review of Patient #10's medical record he could find nothing which indicated facility staff had followed facility policy to ensure a safe and appropriate discharge for Patient #10.

2. Review of Patient #19's medical record showed he was admitted on 5/16/19 at 4:26 a.m. due to suicidal ideation, after rolling his wheelchair into traffic in an attempt to end his life. A Comprehensive Psychosocial Evaluation, completed on admission, noted the patient was homeless and needed placement.

According to the initial nursing assessment, completed on 5/16/19 at 5:21 a.m., the patient was wheelchair bound, had a history of high blood pressure and diabetes. The RN documented Patient #19 had a diabetic foot wound with eschar (dry, dark scab or falling away of dead skin) which measured 1" wide and 1" in length to his right foot stump (amputation) and a

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1¾" long and 1" wide wound to the left lower leg, above the ankle which had yellow purulent (pus) drainage with a pink wound bed.

Review of the History and Physical, completed by the physician on 5/16/19 at 1:10 p.m., showed Patient #19 was legally blind. The physician ordered daily dressing changes for the patient's wounds.

At 12:15 p.m., on 5/16/19, an initial psychiatric evaluation was completed and a treatment plan was put into place by the provider. The treatment plan identified the patient required help with disposition and follow-up appointments, which, according to the physician, would be arranged before discharge.

a. On 5/21/19 at 12:23 p.m., Physician #8 documented, in the psychiatric progress note, that Patient #19 stated he preferred to get placement upon discharge due to having difficulties with his disabilities.

On review of the medical record, there was no documentation that facility staff acknowledged the patient's concerns and attempted any post discharge facility placement for Patient #19.

i. On 5/23/19 at 3:55 p.m., Therapist #2, documented in the Therapy Discharge Note, the patient had no support and was to be discharged to a shelter in Pueblo.

On 5/23/19 at 11:18 a.m., Physician #8 documented in the psychiatric progress note, Patient #19 stated he was "really concerned because I leave tomorrow." The patient stated he

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A 806	Continued From page 15 wanted to return to Pueblo. Physician #8 documented staff were working on disposition and follow-up appointments On 5/23/19 at 7:15 p.m., the mental health technician (MHT) documented in the MHT Group Note, that Patient #19 was unsure about his discharge because the conversation left on a confusing note. The MHT documented the patient was concerned about being homeless again and said he was skeptical about his discharge plan. ii. On 5/24/19 at 2:05 a.m., the registered nurse (RN) documented, in the nursing progress note, she cleaned and dressed Patient #19's wounds and the patient was very concerned about where he would go after discharge and how he would continue to receive the care he needed in a shelter. According to the Discharge/Continuing Care Plan, dated 5/24/19 at 10:45 a.m., Patient #19 was discharged to a homeless shelter in Pueblo with transportation provided by facility staff. Subsequently, on 5/24/19 at 10:07 p.m., an Incident Report was documented by the mental health technician (MHT) who had driven Patient #19 to the shelter in Pueblo. The summary of the incident read, the patient was discharged and transported to Pueblo to a homeless shelter. Upon arrival to the shelter, staff were made aware the shelter had permanently closed. Staff then arranged to take the patient to a shelter in Colorado Springs at which time the patient made suicidal ideation comments. The section titled, To be completed by	A 806		

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supervisor, noted the shelter in Pueblo had reportedly been closed for one year, yet this was where the patient was scheduled to go. RN Supervisor (Supervisor) #18 documented, as the patient did not have a place to go the patient "was discouraged and expressed [suicidal ideation]." The RN supervisor documented the place of discharge needed to be verified as accurate and accepting prior to the patient's discharge by the person who arranged it. The patient was returned to the facility and re-admitted on a mental health (M-1) hold due to his new suicidal ideation.

b. On 5/24/19 at 9:53 a.m., an interview was conducted with Case Manager (CM) #1. CM #1 stated she had received one week of training as a case manager prior to discharging patients. CM #1 stated her job duties included patient follow-up appointments, planning patient after care and providing resources to patients and families related to discharge. CM #1 stated her job was "to make sure discharges [were] safe." CM #1 stated every patient received a follow up with a therapist, psychologist, or primary care provider, resources they needed, emergency contact information, a safety plan, a therapy discharge note, and a discharge summary.

CM #1 stated she reviewed each patient and where they lived, looked for resources for those who required it to include transportation, housing and food. She stated the purpose of the discharge plan was to ensure patients knew where to go if they needed help after discharge and who to follow up with. CM #1 stated a patient had to agree with the discharge plan and staff could not send a patient somewhere they did not

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A 806	Continued From page 17 want to go. A follow up interview was conducted on 5/29/19 at 11:26 a.m., with CM #1. CM #1 stated she had a process in place to ensure a safe discharge and it included three things, a place to go, some way to get there and follow-up appointment set. CM #1 stated these things were required to ensure a safe discharge. CM #1 stated she had set up Patient #19's discharge to the homeless shelter but had never been trained to call the shelter prior to the patient being discharged. CM #1 stated, "if I wasn't trained, how am I supposed to know." CM #1 stated a patient discharged to a homeless shelter should receive the same "safe" discharge as a patient being sent home, but was unable to explain why she did not ensure Patient #19's shelter had been called prior to sending the patient to ensure they had availability and resources to care for the patient. CM #1 stated on 5/24/19 she sent two patients out to shelters without calling prior to discharging them. She stated it would be important to ensure the shelter was able to care for Patient #19 as he was legally blind, in a wheelchair, and required daily wound dressing changes. CM #1 confirmed this had not occurred in Patient #19's case and stated she had not been aware when the patient discharged he had required daily dressing changes. i. On 5/29/19 at 2:07 p.m., an interview was conducted with the clinical services director (Director #12). Director #12 stated after the incident with Patient #19 on 5/24/19, she	A 806		

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provided CM #1 education. Director #12 stated staff were responsible for making sure shelters receiving patients were set up and had the availability and resources to provide post discharge needs for patients. Director #12 stated this had not occurred for Patient #19.

ii. On 05/29/19 at 2:33 p.m., an interview was conducted with RN #7, who discharged Patient #19 on 5/24/19. RN # 7 stated if a patient had wound care needs after discharge, she would try and make sure the patient had the supplies but the facility had minimal wound care supplies and stated "this doesn't always happen."

On review of Patient #19's medical record, RN #7 stated the patient should have gone to a nursing home due to his complicated and extensive medical history but she was unsure why this had not been done.

RN #7 stated she had not provided Patient #19 with any wound care supplies, nor had she called and confirmed the homeless shelter was able to provide or obtain supplies for Patient #19's post discharge needs.

iii. On 5/29/19 at 3:54 p.m., an interview was conducted with Therapist #2, who signed Patient #19's therapy discharge summary. Therapist #2 stated it was case management's job to ensure the patient's discharge location could meet the patient's post discharge needs; to include support, food, shelter, and other basic needs of the patient. Therapist #2 stated this was to ensure a "safe discharge." Therapist #2 stated it was important to call a shelter to confirm they were able to meet the patient's basic needs and

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"that they were even open", which she stated would be the case managers responsibility. Therapist #2 stated she did not confirm discharge plans with facilities, or patients, prior to discharge other than asking patients if they were comfortable with the plan written within the discharge document, titled Discharge Continuing Care Plan.

Therapist #2 reviewed Patient #19's medical record and stated she had trusted CM #1 to set up an appropriate post discharge shelter for Patient #19 and was unaware why CM #1 had not contacted the shelter to ensure they could provide for Patient #19's post discharge needs. Therapist #2 stated "I am so upset because I trusted her to have a safe discharge."
3. Review of Patient #20's medical record revealed he was admitted on 5/16/19. The document, titled Initial Psychiatric Evaluation, noted Patient #20 was an involuntary admission to the facility, endorsed suicidal thoughts with a plan to walk into traffic, and was placed on suicide monitoring. The disposition noted Patient #20 would receive help with follow-up and disposition prior to discharge.

a. Review of the Therapy Services Progress Note, dated 5/22/19, revealed after the therapist presented discharge paperwork to fill out, Patient #20 reported he was unable to participate and the thought made him anxious and suicidal. Patient #20 reported he would not be safe to discharge and would be a threat to himself if he were to leave.

The Psychiatric Progress note, dated 5/23/19, read Patient #20 still reported feeling nervous

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A 806	Continued From page 20 about discharge. Additionally, the next level of care upon discharge was documented as being a shelter, with outpatient follow-up. Review of the Discharge Summary, dated 5/24/19, showed the disposition upon discharge was requiring placement, a therapist, and psychiatric prescriber. Review of the Incident Report, written on 5/24/19, revealed Patient #20 was supposed to be discharged to a facility in Canyon City and upon arrival to the facility, after business hours, the facility reported to transport staff, they had no beds available at their facility, and staff at the outpatient facility, which the patient was discharged to, obtained a motel for Patient #20. Supervisor #18 documented Patient #20 was dropped off at a location (hotel) arranged by the outpatient facility and the outpatient facility staff stated they had not been contacted prior to arrival of Patient #20, and no assessment had been arranged for Patient #20. b. On 5/29/19 at 2:15 p.m. an interview was conducted with the case manager responsible for discharge planning (CM #1). CM #1 confirmed she provided discharge planning for Patient #20. CM #1 stated she assumed Patient #20 would have shelter when he was dropped off at the outpatient location where she referred him to, which was 160 miles from the facility. CM #1 stated when staff arrived to the outpatient facility it was closed. CM #1 stated she spoke with a representative at the outpatient location and they said she could drop off Patient #20 "whenever." CM #1 stated she was unaware the facility did not provide 24 hr stabilization care, and she had	A 806		

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not confirmed hours of operation with the representative she spoke with prior to discharging Patient #20. CM #1 stated there was a lack of communication on her part and she thought Patient #20 could go to the outpatient location and receive respite care (temporary housing) at any time. CM #1 stated she would have documented her conversation in the Communication Log; however, she could not provide documentation she spoke with staff at the outpatient facility prior to discharging Patient #20. Review of the document titled, Communication Log, revealed the document was blank.

CM #1 stated the risk of transporting patients to an unopened facility was that the patients would have no housing on arrival. CM #1 stated the discharge instructions had not included which staff Patient #20 would follow up with or the hours of operation for the facility. CM #1 stated it was important for patients to know who they would follow up with after discharge. CM #1 stated she had not met with Patient #20 on the day of discharge to discuss or review his discharge plan. CM #1 stated the therapist and the nurse would discuss the plan with Patient #20. CM #1 was unable to provide evidence she spoke with nursing staff, or therapy, to convey a plan for Patient #20.

CM #1 stated it was not in her practice to speak with patients regarding their discharge plan prior to discharging them from the facility. CM #1 confirmed she did not involve Patient #20 in the discharge plan. CM #1 stated it was the therapist job to discuss the discharge plan with the patient, and by the therapist speaking with the patient on the day of discharge that involved the patient in

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A 806	Continued From page 22 the discharge process and plan. CM #1 stated she was working to create a discharge process because there was currently no standard discharge process in place at the facility. CM #1 stated at the end of the first week the surveyors were onsite, 5/24/19, she began calling to confirm appointments, verify facilities were aware patients were coming, and verify services that would be provided. CM #1 stated prior to that she had not followed a standard plan for discharges. CM #1 stated she did not have any written guidelines to show the discharge process. CM #1 stated it was important to have a discharge plan to ensure patients were discharged to a safe environment. i. On 5/29/19 at 3:54 p.m., an interview was conducted with Therapist #2. Therapist #2 stated she was a therapist, and not a discharge planner. Therapist #2 stated it was the responsibility of the discharge planner to confirm housing with patients prior to discharge. Therapist #2 stated she did not confirm discharge plans with facilities, or patients, prior to discharge other than asking patients if they were comfortable with the plan written within the discharge document, titled Discharge Continuing Care Plan. Therapist #2 stated she was unsure what type of a facility Patient #20 was being discharged to when she reviewed the discharge plan with him. Therapist #2 stated it was important to confirm there were beds available for shelter, and the facility's hours of operation, prior to discharge to ensure a safe discharge process.	A 806		
A 811	DISCUSSION OF EVALUATION RESULTS CFR(s): 482.43(b)(6)	A 811		

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A 811	Continued From page 23 The hospital ... must discuss the results of the evaluation with the patient or individual acting on his or her behalf. This STANDARD is not met as evidenced by: Based on interviews and document reviews, the facility failed to involve and notify the patient's legal representative with the final discharge plan and placement in 1 of 7 patients who had a guardian involved in their care (Patient #4). Findings include: Facility policy According to the Discharge and Continuing Care Planning policy, discharge planning is an organized, coordinated process with multidisciplinary team, patient and family input which identifies the patient's needs after discharge, delineates plans to meet these needs and teaches the patient and family how to implement the plans. Family teaching and involvement are important as family support will make a big difference after discharge. The family needs to know about the illness, treatment and accomplishments. They also must be told what changes to look for and who to call for help. When making plans, the staff should consider the patient's living situation. 1. The facility failed to ensure Patient #4's legal guardian was actively engaged in the final discharge plan and failed to notify the legal guardian when the patient was discharged. a. Review of Patient #4's medical record revealed the patient was admitted on 4/23/19 for hallucinations, delusions and responding to	A 811		

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A 811	Continued From page 24 internal stimuli and was discharged on 5/14/19. According to the Initial Psychiatric Evaluation on 4/23/19 at 6:02 p.m., the patient was placed on a mental health hold (M-1), which was initiated prior to arrival. The M-1 read, the guardian and assisted living facility staff reported the patient had dysregulation, extreme agitation and was responding to internal stimuli. It was determined Patient #4's insight and judgment were impaired. Continued review of the medical record revealed, court documentation dated 2/26/97, which read, the patient had a legal guardian as it was determined the patient was unable to manage her affairs. The guardian was required to make provision for her care, comfort and maintenance. b. A review of the Communication Log revealed from 4/23/19 until 5/8/19, Case Manager (CM) #1 was communicating with Patient #4's legal guardian about the patient's discharge plan. Review of the last documented communication between CM #1 and Patient #4's legal guardian, showed as of 5/8/19, the discharge plan was still in process. According to the note, dated 5/8/19 at 12:35 p.m., CM #1 documented Patient #4's legal guardian came to visit the patient. CM #1 documented she met with the guardian to discuss progress with placement after discharge and the legal guardian was going to send the case manager a list care facilities. c. On 5/24/19 at 9:53 a.m., an interview was conducted with Case Manager (CM) #1. CM #1 stated she had received one week of training as a case manager prior to discharging patients. CM #1 stated her job duties included patient	A 811		

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follow-up appointments, planning patient after care and providing resources to patients and families related to discharge. CM #1 stated if a patient had a guardian, staff would initiate contact to get them involved in the whole process to include updates on patient and staff progress, discharge plans and where staff were on placement.

CM #1 then reviewed Patient #4's medical record, including the communication log. On review, CM #1 stated Patient #4 had both a legal guardian and an insurance company involved in the patient's discharge plan. CM #1 stated she did not find out Patient #4 had been accepted to an skilled nursing facility until the day before discharge because Patient #4's insurance company had taken over Patient #4's discharge plan. She stated the insurance company made the final decision on the patient's discharge placement. CM #1 stated Patient #4's insurance company was supposed to call Patient #4's legal guardian with the discharge update and placement of the patient.

Review of the emails provided by CM #1 revealed no documentation staff had spoken to Patient #4's legal guardian after 5/8/19, to notify the legal guarding regarding the patient's discharge date and final discharge disposition.

d. On 5/29/19 at 2:07 p.m., an interview was conducted with the Clinical Director (Director #12). Director #12 stated she provided oversight of case management and was involved in patient discharges, to include Patient #4.

Director #12 stated Patient #4's discharge had

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A 811	Continued From page 26 been complicated because the patient had family, legal guardian and an insurance company which were very involved in her discharge. On review of Patient #4's medical record, Director #12 could find no documentation the legal guardian had been involved, updated or notified of Patient #4's discharge plan after 5/8/19. Director #12 stated she had spoken to the legal guardian who requested the facility have the insurance company find Patient #4 post discharge placement. Director #12 stated she had assumed the legal guardian and the insurance company communicated and the legal guardian was aware of Patient #4's discharge plan and placement from the insurance company. Director #12 stated once the insurance company found Patient #4 placement, the process was rushed and she had assumed the legal guardian had been notified. Director #12 stated it would have been important to notify the guardian as "she was the guardian; she needed to know".	A 811		