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	175543	A. BUILDING _____ B. WING _____	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MCLEAN, INC	777 N MCLEAN BLVD WICHITA, KS 67203

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00145178. The 2567 was electronically sent to the facility on 09/12/19.	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 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 622		

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

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 622	Continued From page 1 (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)(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.	F 622		

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F 622	Continued From page 2	F 622		

(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:
The facility had a census of 33 residents, with five residents selected for sample. Three sampled residents discharged/transferred from the facility to another facility within the past two months. Based on interview and record review, the facility failed to communicate appropriate information (contact information of the practitioner responsible for care of the resident, resident representative information including contact information, Advance Directive information, all special instructions for ongoing care, and/or comprehensive care plan goals) to the receiving health care facility for three of three residents. (Resident (R) 1, R4, and R5)

Findings included:

- Resident (R)1 admitted to the facility on 08/17/19 and transferred to another long term care (LTC) facility on 08/27/19.

Discharge/transfer documents included an

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08/27/19 "Discharge Instructions for Care" with specific sections included for documentation of R1's information. The document lacked information related to R1's prescribed diet, physician contact information, pharmacy name/contact information, follow up appointments scheduled for R1, and a signature of the person who completed the form.

An 08/27/19 "Universal Transfer Form" also included specific sections to record information about R1. The document lacked information related to laboratory testing and results, advanced directives, fall history while residing at the facility, cognitive status, use of antibiotics within the previous two weeks, follow up appointments, and the resident's skin condition at the time of discharge.

During a confidential interview on 09/10/19 at 03:50 PM, a former resident's unidentified family member reported the facility failed to advise the receiving facility of scheduled medical/surgical appointments upon transfer which resulted in the resident missing the appointments.

During an interview on 09/11/19 at 03:30 PM, Administrative Nurse D reported the advanced directive and diet information could be found on the copies of orders sent with the resident upon transfer/discharge. Administrative Nurse D confirmed the receiving facility should not have to sort through multiple documents in order to find out basic information about residents.

The facility's 12/2016 "Transfer or Discharge, Preparing a Resident for" policy directs nursing staff to "prepare the discharge summary and post-discharge plan of care." The policy lacks

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F 622	Continued From page 4	F 622		

guidance related to completion of the discharge forms and/or required information that should be provided to the receiving facility.

The facility failed to communicate appropriate information about R1 (current diet, physician contact information, pharmacy name and contact information, follow up appointments, laboratory test results, advanced directives, fall history while residing at the facility, cognitive status, use of antibiotics in the previous two weeks, and skin condition at the time of transfer) to the receiving health care facility upon transfer.

- Resident (R) 4 admitted to the facility on 07/16/19 and discharged to another long term care (LTC) facility on 07/30/19.

Discharge/transfer documents included an 07/29/19 "Universal Transfer Form" which included specific sections to record information about R4. The document lacked information related to a summary of the resident's "inpatient course" while at the facility, cognitive status for decision making, diet orders, follow up appointments, use of antibiotics within the previous two weeks, and skin condition at the time of discharge.

During a confidential interview on 09/10/19 at 03:50 PM, a former resident's unidentified family member reported the facility failed to advise the receiving facility of scheduled medical/surgical appointments upon transfer which resulted in the resident missing the appointments.

During an interview on 09/11/19 at 03:30 PM, Administrative Nurse D reported the advanced directive and diet information could be found on

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F 622	Continued From page 5	F 622		

the copies of orders sent with the resident upon transfer/discharge. Administrative Nurse D confirmed the receiving facility should not have to sort through multiple documents in order to find out basic information about residents.

The facility's 12/2016 "Transfer or Discharge, Preparing a Resident for" policy directs nursing staff to "prepare the discharge summary and post-discharge plan of care." The policy lacks guidance related to completion of the discharge forms and/or required information that should be provided to the receiving facility.

The facility failed to communicate appropriate information about R4 (summary of the resident's stay at the facility, cognitive status for decision making, diet orders, follow up appointments, use of antibiotics within the previous two weeks, and skin condition at the time of discharge) to the receiving health care facility upon transfer.

- Resident (R) 5 admitted to the facility on 08/16/19 and discharged to another long term care (LTC) facility on 08/27/19.

Discharge/transfer documents included an 08/27/19 "Discharge Instructions for Care" with specific sections included for documentation of R1's information. The document lacked information related to R5's follow up appointments.

Transfer documents also included an 08/27/19 "Universal Transfer Form" which included specific sections to record information about R5. The document lacked information related to laboratory testing and results while a resident at the facility, advanced directives, recent falls, a summary of

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F 622	Continued From page 6 the resident's "inpatient course", cognitive status for decision making, current use of antibiotics and/or use of antibiotics in the previous two weeks, and follow up appointments. During a confidential interview on 09/10/19 at 03:50 PM, a former resident's unidentified family member reported the facility failed to advise the receiving facility of scheduled medical/surgical appointments upon transfer which resulted in the resident missing the appointments. During an interview on 09/11/19 at 03:30 PM, Administrative Nurse D reported the advanced directive and diet information could be found on the copies of orders sent with the resident upon transfer/discharge. Administrative Nurse D confirmed the receiving facility should not have to sort through multiple documents in order to find out basic information about residents. The facility's 12/2016 "Transfer or Discharge, Preparing a Resident for" policy directs nursing staff to "prepare the discharge summary and post-discharge plan of care." The policy lacks guidance related to completion of the discharge forms and/or required information that should be provided to the receiving facility. The facility failed to communicate appropriate information about R5 (follow up appointments, lab tests and results, advanced directives, recent falls, a summary of the resident's stay at the facility, cognitive status for decision making, and current use of antibiotics and/or use of antibiotics in the previous two weeks) to the receiving health care facility upon transfer.	F 622		
F 694	Parenteral/IV Fluids	F 694		

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F 694 SS=D	Continued From page 7 CFR(s): 483.25(h)	F 694		

§ 483.25(h) Parenteral Fluids.
Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 33 residents, with five residents selected for sample. Based on observation, interview, and record review the facility failed to maintain a peripherally inserted central catheter (PICC- a form of intravenous access that can be used for a prolonged period of time) for one of five sampled residents. (Resident (R) 3)

Findings included:

- Resident (R)3 admitted to the facility on 09/05/19 following hospitalization for multiple rib fractures which resulted from a fall at home.

The 09/05/19 "Admission Nursing Assessment" noted the presence of a peripherally inserted central catheter line in R3's right upper arm.

The 09/05/19 physician orders lacked an order for a PICC line and lacked orders for routine care/maintenance of the PICC line in order to maintain patency (keep the tube unblocked/open).

R3's initial care plan initiated at the time of admission on 09/05/19 lacked mention of the PICC line in the right upper arm.

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F 694	Continued From page 8	F 694		

An 09/08/19 "Interdisciplinary Note" written at 04:41 PM described the removal of the PICC line to R3's right upper extremity.

Review of medication administration records and treatment records for the time period from 09/05/19 - 09/08/19 lacked evidence of flushes and/or care of the PICC line during that three day time period.

During an interview on 09/11/19 at 10:00 AM, R3's unidentifed family member reported she told staff about the presence of the PICC line on the date of admission on 09/05/19. According to the unidentified family member, she advised "nurses" on several occasions the need to flush the line two or three times a day to prevent a blood clot. The unidentified family member reported, "No one listened to me. I just knew he would get a blood clot since they weren't taking care of it."

During an interview on 09/11/19 at 03:30 PM, Administrative Nurse D reported the admitting nurse noted the presence of the PICC line in R3's right upper arm but failed to contact the physician to either get an order to continue the PICC line or remove it. Administrative Nurse D confirmed the PICC line remained in R3's right upper arm until 09/08/19 when staff obtained a physician's order to remove it. During that three day time period, nursing staff failed to monitor the PICC line and/or flush it to maintain patency.

In response to a request for policy related to routine care/maintenance of a PICC line, the facility provided an undated "Infusion Maintenance Table" which included specific types of intravenous devices, including PICC lines. That document listed maintenance requirements for

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F 694	Continued From page 9 different types of PICC lines, including routine flushes of the lines with normal saline and/or injection of heparin, a substance that prevent blood clot formation. The facility failed to have a physician's order for a PICC line present in R3's right upper arm at the time of admission, failed to notify the physician of the presence of the PICC line and either get an order to discontinue it or get orders for maintenance of the PICC line, and failed to monitor/flush the PICC line for a three day time period.	F 694		