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Presenting a live 90-minute webinar with interactive Q&A

Nursing Home Malpractice: Indispensable Discovery for Establishing Causation, Systemic Neglect, and Liability

Discovering Nursing Home Patterns and Practices, Key Caregivers, Nursing Policies, Administrative Procedures, Cost Information

TUESDAY, JULY 27, 2021

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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Jaime Koziol Delaney, Partner, **Levin & Perconti**, Chicago, IL

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The audio portion of the conference may be accessed via the telephone or by using your computer's speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact **Customer Service at 1-800-926-7926 ext. 1**.

Nursing Home Case Pre-Suit Investigation

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Nursing home litigation is a very document-intensive practice. Fortunately, obtaining many of the documents necessary to conduct a pre-suit investigation of your case is possible through state and federal agencies with Freedom of Information Act (FOIA) Requests.

Knowing what documents are available and how to obtain them is imperative to the success of any nursing home practice. Once these documents are received, you can develop case themes and discovery strategies, even before filing suit.

The following is a list of vital documents to conduct a pre-suit investigation of your case.

1) Resident's nursing home chart

The first document to request in any nursing home case is the entire nursing home resident chart. It is rare to receive all the documents mentioned below in the first request. Many nursing homes maintain portions of a resident's chart outside their electronic medical record (EMR). Knowing what should be included as part of the resident's chart allows you to follow up with subsequent requests to obtain all the necessary information to conduct a pre-suit evaluation of the case (see Point Click Care electronic medical records checklist).

Components of a nursing home record

1. Administrative
    - Face sheet
    - Consents
        - Prolonged device (foley catheter, G-Tube, NG-Tube, colostomy)
        - Physical restraint
        - Psychotherapeutic medications
    - Hospital transfer forms
    - Advance directives

2. Prior hospital records
    - Emergency room records
    - Transfer summary
    - Discharge summary

3. Physician orders and progress notes
    - Should include history & physical
    - Miscellaneous orders (pharmacies, dietary changes, therapy orders)

4. Consultations
    - Surgical
    - Psychiatry
    - Podiatry
    - Dental
    - Ophthalmology
    - Optometry

5. Minimum Data Set (MDS) assessments
    - Make sure all MDS assessments are included
    - Request CAA summary worksheets
    - Comprehensive MDS can take 3 to 4 hours to complete; look for documentation to support what they coded
    - Depose MDS coordinator
    - Fall case: history of falls at admission? Fall risk assessment? Did they report the fall?
    - Pressure injury case: noted upon admission? Did they "back-date" the stage? Compare to wound assessments

6. Care Plans
    - Baseline care plan completed within 48 hours of admission?
    - Comprehensive care plan implemented and re-evaluated when necessary?

7. Nursing assessments and nursing notes
    - Admission assessments should be included (fall risk, Braden, pain, incontinence, wandering/elopement, etc.)
    - Monthly/quarterly summaries may be included

8. Medication administration record (MAR)
    - Narcotic records
    - Side effect monitoring records

9. Treatment administration record (TAR)
    - Did staff follow physician orders?

10. Pressure ulcer/skin integrity documents
    - Make sure you have records for admission and re-admissions

- Documents evidencing skin checks/skin report
- Wound tracking records

11. Vitals, weights, intake/output records
    - Did the resident experience a significant weight change?

12. Therapy records
    - Physical
    - Occupational
    - Speech
    - Respiratory

13. Dietary records

14. Activity & recreational therapy records

15. Social services
    - Discharge planning records

16. Labs, radiology, and diagnostic testing

17. Activities of Daily Living (ADL) flowsheets

2) Documents to request from state agencies

Once you have the nursing home chart, it is essential to request documents from the state survey agency. Be strategic in drafting FOIA requests. Request the required records to screen the case first, i.e., surveys, license, etc. Follow up with additional FOIA requests to reduce costs. Although state law varies on the scope of disclosure of public information made through FOIA Requests, the following are documents frequently obtainable through the state agency in charge of the licensure and certification of nursing homes in your state.

1. Licensure file
    - Current license
    - Application and forms

The licensure file includes basic but essential information about the facility itself, such as its owner/operator, bed capacity, and licensure expiration dates. The licensure file should consist of the current license as well as any applications and accompanying forms.

The application, along with accompanying forms, provides a wealth of information to use in your case. The application includes the identity of the owner, whether a

management company operates the facility and the various percentages of ownership. The application also consists of a facility floor plan (useful in fall cases to show that your client's room was too far from the nursing station) and programs within the facility, such as a secure dementia unit or ventilator unit.

2. Statement of Deficiencies and Plan of Correction (CMS 2567)
    - Framework for systemic quality of care issues
    - History of non-compliance?
    - Was the facility cited relating to your case?

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to comply with the Omnibus Budget Reconciliation Act (OBRA) of 1987, as well as federal nursing home regulations, known as the Requirements of Participation for Long-Term Care Facilities. State survey agencies conduct annual nursing home inspections and may inspect facilities more often based on complaints or incidents that the facility reports. States decide how often they will inspect nursing homes under state laws and regulations. If, during an inspection, the surveyor finds that a nursing home is not meeting federal guidelines, then the nursing home receives a citation or deficiency. The surveyors then compile the findings of the inspection into a survey known as CMS Form 2567. If a facility receives a deficiency, they must submit a plan of correction describing how they will correct the harmful practice. To obtain copies of current or past surveys, you can submit a FOIA Request for all "*Statement of Deficiencies and Plans of Correction*" from a particular period.

3. General information
    - Bed capacity, Medicare/Medicaid certification
    - Rating
    - Penalties

4. Ownership information
    - Current corporate structure and ownership
    - Any recent change in facility ownership (CHOW)

3) Investigative documents

1. EMS records
    - What did EMS personnel document when they arrived?
    - Call EMT at trial to describe the scene

2. 911 tape

If the nursing home called 911 relating to your case, you might want to request the 911 tape to confirm or contradict the facility's versions of events. It is wise to do this

early on as many departments erase 911 tapes after a relatively short period.

3. Police file

If there is a police investigation related to your case, it is always wise to request the entire file, including notes taken during an investigation. If there is an ongoing criminal investigation, they may produce a redacted version. Be sure to re-request the whole file once the police complete their investigation, as they often send you much more the second time around.

4. APS/Ombudsman records (see APS case narrative)

Always ask your clients whether Adult Protective Services (APS) or the ombudsman was contacted or involved in the case. Often, a hospital will report an issue to APS, so make sure to search those records. Requesting the APS file or ombudsman correspondence can be a goldmine for discovering communications between the facility and those agencies.

4) Documents to request from the Centers for Medicare & Medicaid Services (CMS)

A FOIA Request to CMS should also be made early on during the initial case evaluation to procure documents that weren't available through state agencies, such as the facility cost report. To make a FOIA Request to CMS, email FOIA_Request@cms.hhs.gov or send the request directly to the appropriate CMS Regional Office. After receiving the initial request, CMS must respond within 20 working days as to their disclosure. CMS FOIA guidelines, as well as fee schedules, are available at https://www.cms.gov/Regulations-and-Guidance/Legislation/FOIA/.

1. Medicare Cost Report (CMS 2540-10)

A nursing home's financial report card, the Medicare Cost Report, contains an accounting of every single dollar going in and out of the facility during the calendar year (or another period if stated). The Cost Report includes data necessary to allege understaffing and related "profits over people" arguments in your case.

2. Home Office Cost Statement (CMS 287-05)

If a nursing home is part of a chain organization, the chain must also submit a Home Office Cost Report. This lengthy document contains information about individual facilities that are part of the chain, including the costs attributable to each facility and its revenues. In most cases, obtaining this document will discredit their argument that each facility operates independently from its corporate counterparts and is operationally one business.

3. Medicare Enrollment Application (CMS 855A/PECOS)
    - CMS 855A is the paper application
    - Must be completed at 1) initial enrollment 2) revalidation 3) change of information 4) change of ownership
    - Can choose to use the internet-based Provider Enrollment, Chain and Ownership System (PECOS) application instead
    - https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf

4. ASPEN Complaints/Incidents Tracking System (ACTS) (see ACTS Complaint/Incident Investigation Report)
    - Intake system for complaints

5. Facility Assessment (42 CFR § 483.70(e))
    - All SNFs must conduct and document a facility-wide assessment to identify resources required to care for residents during normal operations and emergencies.
    - Three parts:
        i. Resident profile and factors that impact care and support needs.
        ii. Services and care offered based on resident needs.
        iii. Resources needed to provide competent care for residents.

5) Publicly available resources

1. Social media information (see attached yelp review with family complaints of poor care)
    - Facebook, twitter, Instagram
    - Nursing home website

2. Nursing home reviews
    - Yelp, Google, Facebook

3. Advertisements
    - What did the facility advertise to consumers about the quality of care and specialty services provided?

4. Job listings
    - Did the facility post job listings?
    - What did the facility advertise that position required? (i.e., no experience necessary)
    - Use to compare to job descriptions obtained during discovery

5. Board of Nursing documents
    - License search
    - Disciplinary proceedings
    - Nurse aide registry list
    - How long did they have their license when your event happened?

6. Background checks/criminal history searches

7. Corporate Integrity Agreements (CIA)

Point Click Care (PCC) - Electronic Medical Records Checklist

Patient's Name [redacted]

Note: Click on active medical record form and all retired versions to locate appropriate records.

Include a copy of the completed checklist when submitting records to Legal Counsel.

Medical Record Form	Printing Instructions	Check as Produced or N/A
Admission Record (Facesheet)	• Select Clinical tab and click on *Patients* • Select *Current* or *Discharged* as appropriate • Select the Patient • Within the patient record, select the *Profile* tab • Select *Admission Record* • Click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)	✓
Vaccine Record	• Select Clinical tab • Under Other category, select *Reports* • Under General Clinical Reports, select *Immunizations Report* • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass • Select *Current or Discharged* as appropriate • Select the patient • Change the date range to match the time period required • Click on the *Run Report* button in the upper right corner • Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Change Orientation to Landscape before printing	✓
Care Plan	Select Clinical tab • Under Other category, select *Reports* • Under Care Plans/Tasks select *Care Plan* • Select the patient • Change Care Plan from *Most Recent* to *All* • Select *Tasks, Revision History* and *Resolved/Cancelled Care Plan Items* • Now Run the Report	✓
Physician Progress Notes Nurses Progress Notes Dietary Progress Notes Discharge Planning Progress Notes Activities Progress Notes	• Select Clinical tab • Under Other category, select *Reports* • Under General Clinical Reports header, select *"New"" Progress Notes* • Under *Report Options:* Select *Patient* and search for patient's name or enter patient # and click on the looking glass icon • Change the Effective Date Range to the appropriate dates • Under *Progress Note Details* – Uncheck *Show Patient Detail* and *Signature* • Click on the *Run Report* button in the upper right corner • Once the report is viewable –click on the print button to print	✓

Point Click Care (PCC) - Electronic Medical Records Checklist

Medical Record Form	Printing Instructions	Check as Produced or N/A
Rehab/Therapy Notes	• Select Clinical tab • Under Other category, select *Reports* • Under General Clinical Reports header, select *Therapy Clinical Documents* • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon • Change the Effective Date Range to the appropriate dates • Click on the *Run Report* button in the upper right corner • Once the report is viewable –click on the *View* button beside the note to be printed • Once the document is viewable – click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Repeat until all documents are printed	✓
MDS Assessments	• Select Clinical tab and click on *Patients* • Select *Current* or *Discharged as appropriate* • Select the patient • Within the patient record, select the *MDS* tab • To print each MDS, click on the *Print* button beside the MDS you wish to print • Check the *MDS form* • Once the report is viewable – click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Repeat until all MDS are printed.	N/A
Other Assessments	• Select Clinical tab • Under *Other* category, select *Reports* • Under the Assessment header, choose *Assessment Report* • Under *Report Options* enter the patient's name or enter their patient # and click on the looking glass icon • Uncheck *Include Disabled Questions* • At *Assessment Type* click on the looking glass to view types of assessments • In the upper right corner of the pop up screen, check the *Include Retired* button • Check the Assessments (you can choose 10 at a time—do not select MDS 3.0) • Click on the *Update* button located at the bottom of the pop up screen • Click on the *Run Report* button in the upper right corner • Enter the "Date Range" *(will only allow 90 days worth of assessments)* • Click on the *Run Report* button in the upper right corner • Once the document is viewable – click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Once the first 10 assessments have been printed, you will need to click the Looking Glass Icon and *Clear All* button and re-check the next 10 assessments to be printed • Repeat until all documents are printed	✓

Point Click Care (PCC) - Electronic Medical Records Checklist

Medical Record Form	Printing Instructions	Check as Produced or N/A

Orders	• Select Clinical tab
	• Under *Other* category Select *Reports*
	• Under the Orders header, choose *Order Listing Report*
	• Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon
	• Under *Filter Options* only the *Order Status* should be checked.
	• Under *Order Status* the following should be selected:
	  ▪ Active
	  ▪ Completed
	  ▪ Discontinued
	  ▪ On Hold
	  ▪ Pending Confirmation
	  ▪ Pending Clinical Review
	• Under the *Fields to be Displayed* header, the following should be checked:
	• Under Order Details, click *Order Summary*
	• Under Administrative Order Details, click *Discontinued Date*
	• Under Order Scheduling Details, click *Start Date/End Date*
	• Under Order Audit Details, click *Created By/Created Date/Revision Date*
	• All other boxes should be unchecked
	• Click on the *Run Report* button in the upper right corner
	• Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)
		✓

Labs/X-rays	• Select Clinical tab • Under Other category Select *Reports* • Under the Results header, choose the results you want to print • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon • Change the *Reported Date Range* to the dates required • Click on the *Run Report* button in the upper right corner • Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)	✓
Hospital Discharge Summary/H&P Lab/X-ray Reports Consults Pharmacy Reports Medical Progress Notes Flowsheets Etc.	• Select Clinical tab and click on *Patients* • Select *Current* or *Discharged* as appropriate • Select the patient • Within the patient record, select the *Documents* tab • Select the desired document (click on the name of the document) • Click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)	N/A

Point Click Care (PCC) - Electronic Medical Records Checklist

Medical Record Form	Printing Instructions	Check as Produced or N/A
Vital Signs	• Select Clinical tab • Under Other category, Select *Reports* • Under the *Weights and Vitals* header, choose the *Weights and Vitals Summary* • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon • Change the *Effective Date Range* to the dates required • Uncheck the *Warnings* box, *Include User* and *Printed By* • Click on the *Run Report* button in the upper right corner • Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)	✓
Transfer/Discharge Record	• Select Clinical tab and click on *Patients* • Select *Current* or *Discharged* as appropriate • Select the patient • Within the patient record, select the *Profile* tab • Select *Transfer/Discharge Record* • Click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar)	✓
MARS/TARS	• Select Clinical tab • Under Other category, select *Reports* • Under the Orders header, choose the *Administration Record Report* • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon • Check MAR and TAR Administration Records • Select the month and year you want to print • Click on the *Run Report* button in the upper right corner • Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Change the Orientation to Landscape before printing • Repeat until all needed documents are printed	✓
CNA ADL Documentation	• Select Clinical tab • Under *Other* category, select *Reports* • Under the *Point of Care* header, choose the *Documentation Survey Report V2* • Under *Report Options* enter the patient's name or enter patient # and click on the looking glass icon to print • Enter the month and year needed to print • Change the drop down list to *Interventions and Tasks* • Check the *Show User Legend* box • Click on the *Run Report* button in the upper right corner • Once the report is viewable, click on the printer icon to print (located at the bottom of the page when you hover over the Adobe bar) • Change the Orientation to Landscape before printing • Repeat until all needed documents are printed	✓

Point Click Care (PCC) - Electronic Medical Records Checklist

Medical Record Form	Printing Instructions	Check as Produced or N/A
Kardex	• Select Clinical Tab • Under *Other*, select *Reports* • Under the *Care Plan/Task*, select *Kardex* • Under *Report Options*, enter the patient name or number • Change *Position* to *Certified Nursing Aide* • Run Report • Print	N/A

Note: If producing the complete medical record, remember to include the paper chart.

Narrative

Narratives

Case Number: 1880043 Case Name: [redacted]
Worker: LRJ550 Locality: Chesapeake

Contact	Type	Date	End Date	Narrative	LastUpdatedBy	LastUpdatedDate
Martel, Nikole	Phone from	06/08/2016 09:36	06/08/2016 14:36	REPORT: The Victim's daughter visited her and saw her crying; She called EMS and X- Ray showed a fractured right hip, and a bruise on the right wrist/ right arm. The victim could not tell her daughter how it happened. Alleged victim was admitted to Chesapeake General.	EZP550	07/13/2016 09:22
[redacted]	Face to Face	06/10/2016 14:36	06/10/2016 14:36	COLLATERAL CONTACT: FSSIII made a visit to Sentra Nursing Home. FSS was informed by staff Ms. [redacted] was not discharged from CRMC.	EZP550	07/13/2016 09:23
[redacted]	Face to Face	06/10/2016 14:39	06/10/2016 14:45	INTERVIEW WITH CLIENT: FSSIII conduct a visit with Ms. [redacted] in regards to the APS report received on 06/08/2016 at CRMC. Ms. [redacted] is on the second floor in room 2124.FSS was informed by RN staff Ms. [redacted] was heavily medication and was asleep. FSS observed Ms. [redacted] to be asleep in her bed. FSS was unable to conduct the interview.	EZP550	07/13/2016 09:25
[redacted]	Case Action	06/10/2016 14:50	06/10/2016 14:50	COLLATERAL CONTACT: FSS received copies of Ms. [redacted] medical history from CRMC.	EZP550	07/13/2016 09:26
[redacted]	Letter/Fax to	06/10/2016 14:53	06/10/2016 14:53	COLATERAL CONTACT: Referral fax to Ombudsman.	LRJ550	06/30/2016 11:08
Center , Sentara Nursing	Letter/Fax from	06/13/2016 09:00	06/13/2016 09:00	COLLATERAL CONTACT: FSS III, L. Raby-Williams, received face sheet, Investigative summary, and a list of staff that worked with Ms. [redacted] from Sentara Nursing Center.	LRJ550	06/30/2016 11:08
[redacted]	Home Visit	06/24/2016 12:24	06/24/2016 12:24	ATTEMPTED FOLLOW-UP VISIT: FSS Green made an unannounced visit to Ms. [redacted] at Sentara Nursing Home. Ms. Sharp informed FSS Green that Ms. [redacted] did not return to Sentara Nursing from the hospital. Ms. [redacted] daughter moved Ms. [redacted] to another facility after she was discharged from the hospital. Ms. Sharp gave FSS Green a copy of all the nurses and staff that had contact with Ms. [redacted] between 6/4/16-6/6/16. Ms. Sharp did not have access to the final facility report regarding the 6/6/16 incident. Ms. Sharp indicated that the administrator faxed the final report but if it was not received, the administrator would have to refax it. FSS Green will report to FSS III Raby-Williams that Ms. [redacted] is no longer residing at Sentara.	EZP550	07/13/2016 09:28
Care, Autumn	Letter/Fax from	06/29/2016 10:55	06/29/2016 10:56	COLLATERAL CONTACT: FSSIII received medical information and face sheet from Autumn Care of Chesapeake.	LRJ550	06/30/2016 11:19
Schapowal, Nick	Phone to	06/29/2016 14:20	06/29/2016 14:20	COLLATERAL CONTACT: FSSIII spoke with Mr. Nick Schapowal in regards to Ms. [redacted] whereabouts. Mr. [redacted] stated [redacted] was transferred from CRMC to Autumn Care. Mr. Schapowial stated [redacted] passed away at Autumn Care on June 28, 2016. Mr. Schapowail	EZP550	07/13/2016 10:43

Printed: 01/30/2018 3:59:55PM
Due Date:
Priority: No Action Necessary

Intake ID: VA00024994
Facility ID: VA0129 / SNF/NF
Provider Number: 495203
State Region: 001

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: [redacted]
Address:
City/State/Zip/County:
Telephone:

License #:
Type: SNF/NF
Medicaid #: 004952031
Administrator: (b) (6), (b) (7)

INTAKE INFORMATION

Taken by - Staff: (b) (6), (b)
Location Received: COMPLAINT UNIT
Intake Type: Entity Reported Incident
Intake Subtype: Federally-required, entity-reported
External Control #:
SA Contact: (b) (6), (b) (7)(C)
RO Contact:
Responsible Team: CENTRAL LTC
Source: Entity Self-Reported

Received Start: 02/22/2013 At 11:46
Received End: 02/22/2013 At 11:46
Received by: Fax
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Phone	EMail
(b) (6), (b) (7) (Primary)			

Link ID: (b) (6),

RESIDENTS/PATIENTS/CLIENTS

Name	Admitted	Location	Room	Discharged	Link ID
[redacted]					3736230

INTAKE DETAIL

Date of Alleged: 02/21/2013 Time: Shift:

Standard Notes: Resident alleged CNA threw in bed like a sack of potatoes. CNA suspended pending investigation.

2/27/13- Follow up revealed no abuse/neglect found.

Extended RO Notes:
Extended CO Notes:

ALLEGATIONS

Category: Resident/Patient/Client Abuse
Subcategory: Physical
Seriousness: Moderate
Findings: Unsubstantiated:Lack of sufficient evidence
Details:

Findings Text:

EMTALA INFORMATION - No Data

ACTIVITIES - No Data

INVESTIGATIVE NOTES - No Data

CONTACTS - No Data

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

ACTS Complaint/Incident Investigation Report

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

Reason for Restraint:
Cause of Death:

NOTICES

PROPOSED ACTIONS - No Data

[redacted] Closed: 02/27/2013 **Reason:** Paperwork Complete

END OF COMPLAINT INVESTIGATION INFORMATION

[redacted]

[redacted]

[redacted]

Haunani K.
Richmond, VA
0 friends
8 reviews

2/22/2016
First to Review

Chad Williams Chad Williams Chad Williams .... What can I say ? After hearing my desperate cry for help you professionally assessed the situation accordingly and immediately jumped in and got THINGS DONE! made the transition for my mother very pleasant the tour was extremely welcoming and informative and NOW she feels at home as every single guest of the facility should feel regardless of money, race, sex or religion. ALL OF THE STAFF are very attentive and knowledgable and full of energy and CLEAN . Very satisfying to see that sanitation and cleanliness are taking very serious as they should be in any medical setting, the dining room was set up as a restaurant and not just a room. The physical therapy room was full of new machines and a wonderful lady that was very happy to inform us that if your lazy don't come .. Lol.. And to top it off they allow pets to visit as long as ALL shot records etc are up to date ..OH! Almost forgot I met the very well known Chef Kenneth Woodley and he was very happy to assist in any way he could to make your dining experience a pleasurable one. WHAT ELSE CAN I SAY?!??? see you for breakfast ..

ChrisTina U.
Roanoke Rapids, NC
0 friends
1 review

12/11/2018

Unbelievable...My mother was there for 3 weeks, three weeks too long.
I'm not sure what upset me more, her bedsores (she is 81 & been in a few rehab centers here), she has NEVER come home with bedsores. When they discharged her, they provided transport because at this time my mother is bed bound, they brought her into the foyer/common area in a wheelchair & left her...alone. Just thankful there was staff still at work to notify me that she was in the hallway. After getting her home, I looked into the bag with personal belongings for discharge paperwork & medication lists/RX that I would go by until she physically went back to her doctor...nope, no discharge paperwork, no RX. So the next morning first thing, I went to Bay Point to at least get a copy of discharge instructions. I tried to speak to social worker but she was in a meeting. The young lady that came up front was just plain rude. She stated that they don't furnish discharge instructions...Um you are the only rehab I know that has that practice. Once again my mother is 81, she has had a few surgeries & been in rehab multiple times, this is the FIRST time I have not been provided discharge instructions & post-rehab medications. Thankful I have doctors & nurses that guided me in the right direction. I would not let them near my dog & I would not reccommend this facility to anyone.

Comment from Eric B. of Kindred Transitional Care and Rehabilitation - Bay Pointe
Business Owner

12/12/2018 · This facility is now operated by Sentosa Care. Please contact robi@sncny.org to provide more

Sat Open 24 hou
Sun Open 24 hou
Edit business info

Haunani I
First to revie

You might also cc

People also viewe

Professic Rehab Ce
Chiropractc Massage...

Other places neai

Find more Rehabilitat Kindred Transitional (Rehabilitation - Bay F

Find more Skilled Nui Transitional Care and Pointe

Browse nearby

- Restaurants
- Nightlife
- Shopping
- Show all

Near Me

Drug Counseling Nea