State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 92-3082-0013753-F

Date: 01/19/2018 Time: 3:34pm.

Type of Visit : Complaint Investig.

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00560365

Licensee Name: Griffith Park Rehabilitation Center, LLC.

Address: 201 Allen Avenue Glendale, CA 91201

License Number: 920000035 Type of Ownership: Limited Liability Company

Facility Name: Griffith Park Healthcare Center

Address: 201 Allen Ave Glendale, CA 91201

Telephone: (818) 845-8507

Facility Type: Skilled Nursing Facility Capacity: 94

Facility ID: 920000018

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 1/19/18 11:59 p.m.

F624

CLASS B CITATION -- ADMINISTRATION

F624

§483.15(c) (7) Orientation for transfer or discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

On 11/17/17 at 11:40 a.m., an unannounced visit to the facility was conducted to investigate a complaint regarding physician services and quality of care.

Based on interview, and record review, the facility failed to safely discharge Resident 1 by failing to:

1. Arrange transportation upon the resident's discharge from the facility.

The facility's administrator (ADM) left Resident 1 alone at a train station, on 11/10/17 to go to home to a different city (approximately 145 miles) without ensuring the resident's safe travels.

This deficient practice resulted in Resident 1 not arriving home on 11/10/17, and she was missing for 6 days.

Name of Evaluator:
Minerva Reyes
HFEN

Evaluator Signature :

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature :

Name : Yolanda B. Gasmen

Title : Asst. Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

A review of Resident 1's clinical record indicated the resident was admitted to the facility, on 11/02/17, with diagnoses that included schizophrenia (serious mental illness characterized by incoherent or illogical thoughts, bizarre behavior and speech, and delusions or hallucinations, such as hearing voices), major depression, abnormal posture, gait, and mobility. Resident 1 was taking antipsychotic medications (mind altering medications).

A review of Resident 1's physician's order, dated 11/10/17, indicated to discharge the resident home with all medications except Klonopin (medication that used to treat certain seizure disorders).

On 11/17/17 at 11:47 a.m., during an interview, the Registered Nurse (RN 1) stated Resident 1 was discharged from the facility on 11/10/17. RN 1 stated that the ADM took Resident 1 to the train station to go to a different city (approximately 145 miles from the facility).

On 11/17/17 at 12:29 p.m., during an interview, the facility's Social Services Designee (SSD) stated Resident 1's family member (FAM 1) arranged the discharge with the facility's ADM. The SSD stated he did not follow up with Resident 1 after the resident was discharged on 11/10/17. The SSD stated that he was supposed to follow up to make sure Resident 1 got home safe.

On 11/17/17 at 1:40 p.m., during a telephone interview, the ADM stated that he took Resident 1 to the train station, on 11/10/17, at approximately 1:15p.m. The ADM stated Resident 1 did not have a train ticket, and he did not know whether Resident 1 rode the train or not. The ADM stated that he left Resident 1 in the train station without first ensuring her safety. The ADM stated, "I trusted her." The ADM stated that he did not follow up to ensure Resident 1 made it home. The ADM stated that Resident 1's FAM 1 called him on 11/11/17 and told him that the resident did not arrive home. The ADM stated that he did not know where Resident 1 was. The ADM stated he called hospitals around the facility, and the Amtrak police with "no luck." The ADM stated "we are praying for her."

A review of Resident 1's Physician's Discharge Summary, undated, indicated the resident was discharged on 11/10/17 with diagnoses that included abnormal posture, gait, and schizophrenia.

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	A review of Resident 1's Minimum Data Set ([MDS], a standardized assessment and care-screening tool, dated 11/9/17, indicated Resident 1 had intact cognitive skills (the brain/mind processed information in a normal way), and required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) for walking, dressing, and personal hygiene requiring one person to assist. The MDS indicated Resident 1 required extensive assistance (resident involved in activity; staff provide weight-bearing support) for toilet use requiring one person to assist. A review of Resident 1's Balance Assessment dated 11/3/17, indicated that resident was at high risk for falls. A review of Resident 1's Antipsychotic Medication Administration Record, dated 11/10/17 and timed at 9 a.m., (approximately two hours before discharge), indicated Resident 1 was given Seroquel (antipsychotic medication),100 milligrams (mg), by mouth. According to Food and Drug Administration (FDA) at:https://www.accessdata.fda.gov/drugsatfda_docs/nda/2011/020639orig1s049lbl.pdf, indicated that the most common side effects of taking Seroquel are dry mouth, dizziness, weakness, abdominal pain, and difficulty moving. A review of Resident 1's Care Plan titled "Delirium," (abrupt change in baseline mental status; fluctuating level of consciousness; confused, disorganized speech), dated 11/2/17, indicated that Resident 1 had the potential for acute confusion different from normal baseline related to psychoactive medications. The staff approached intervention was to provide optimal level of environmental stimulation. A review of Resident 1's Licensed Nurses' Narrative Notes, dated 11/10/17 and timed at 1:30p.m., indicated that Resident 1 was taken to a train station by the ADM. A review of Resident 1's Licensed Nurses' Narrative Notes, dated 11/13/17 (three days after Resident 1 was discharged from the facility), and timed at 11:15 a.m., indicated that Resident 1's FAM 1 spoke with the ADM and indicated that Resident 1 did not get home and was missing. On 11/17/17 at 8:18 a.m., during a telephone interview, Resident 1's FAM 1 stated he filed Resident 1 as a missing person on 11/11/17. FAM 1 stated on 11/16/17, he

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	received a call from a police officer from a different city (approximately 55 miles from Resident 1's home), indicating Resident 1 was found nude wandering the streets. On 11/17/17 at 1:23 p.m., during an interview, RN 1 stated that Resident 1 was taking antipsychotic medications and needed a family member or someone to physically take Resident 1 home to ensure a safe discharge. A review of the facility's policy and procedure titled "Discharge Summary and Plan," with a revised date of December 2016, indicated that the facility required staff to evaluate resident for his or her discharge needs. The facility failed to safely discharge Resident 1 by failing to: 1. Arrange transportation upon the resident's discharge from the facility. The facility's failure to safely discharge Resident 1 put the resident and her family member at risk for physical, mental, or psychosocial harm. This violation had a direct relationship to the health, safety or security of Resident 1.