CITATION NUMBER: 910015450

Date: 10/10/2019 12:00:00 AM

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) : CA00645756

Licensee Name: Hyde Park Rehabilitation Center, LLC
Address: 6520 West Blvd. Los Angeles, CA 90043
License Number: 910000066 Type of Ownership: Profit Corp

Facility Name: Hyde Park Healthcare Center
Address: 6520 West Blvd Los Angeles, CA 90043
Telephone : (323) 753-1354
Facility Type: Skilled Nursing Facility Capacity: 72
Facility ID: 910000049

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: A CITATION: Patient Rights	20000.00	10/10/2019 11:59:00 PM

483.15(c)(1)(i)(ii)(2)(i)-(iii)
483.25
T22 DIV5 CH3 ART5-72523(a)
483.15(c)(1)(i)(ii)(2)(i)-(iii)

CLASS A **CITATION --** Patient Rights

F622
§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.

F684
§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents'

Name Of Evaluator:
Toimbie Amaazee
HFEN

Evaluator Signature:_____

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

Signature:_____

Name:_____

Title:_____

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choices.

§ 72523. Patient Care Policies and Procedures.
(a)Written patient care policies and procedures shall be established and implemented to ensure that patient-related goals and facility objectives are achieved.

The Department received a complaint on 7/12/19 regarding an unsafe transfer of a resident to a lower level of care.

On 7/13/19, an unannounced complaint investigation was conducted at the facility.

Based on interviews and record review, the facility failed to implement its policies and the residents' plan of care for Residents 1, 2, 3, and 4, who required assistance with care. Residents 1, 2, 3, and 4 were discharged to an unlicensed assisted living facility (UALF) without evaluation to determine whether the residents were clinically stable for discharge to a lower level of care and whether placement in the UALF would be safe and appropriate. The facility's deficient practices included:

1. Failure to implement its policy titled, "Transfer or Discharge Documentation," indicated when a resident was transferred or discharged, the details of the transfers or discharges would be documented in the medical records and a summary of the resident's overall mental, physical and medical condition and the reason for transfer documented in clinical records by the attending physician to determine if the discharge was appropriate for Residents 1, 2, 3 and 4.

2. Failure to ensure Resident 1, who was diagnosed with active tuberculosis ([TB] a contagious bacterial infection that typically attacks the lungs and spreads through the air) and was being followed by the Health Department, was discharged to a lower level of care with the approval of his physician and an adequate amount of TB medications.

3. Failure to adhere to Resident 1's care plan that stipulated the staff would coordinate discharge goals with rehabilitative therapies, arrange a family conference to establish discharge plan, arrange and schedule post discharge appointments and services needed, follow up with the resident/family to assure understanding of plan or answer additional questions and offer opportunity for the resident to visit the potential new home or care center.

These deficient practices resulted in Resident 1 being discharged to an unlicensed home without any care givers (a person who provides direct care to another) and not receiving TB medications for 18 days. Residents 2, 3, and 4, all of whom required assistance with care and medication administration, with Resident 4, who had end stage renal disease ([ESRD] last stage of long-term (chronic) kidney disease; when the kidneys can no longer support the body's needs to filter waste/water) requiring transportation to dialysis treatment three times a week, were also transferred to an UALF and later discharged. The owner of the home refused to provide the whereabouts of Residents 3 and 4.

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a. A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1, was a 73 year-old male, who was admitted to the facility on 3/14/19 with the most recent readmission on 6/24/19. Resident 1's diagnoses included tuberculosis, generalized muscle weakness, psychosis (a mental disorder that causes one to see, hear and believe things that are not real) and bipolar disorder (mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly).

A review of Resident 1's "Tuberculin Skin Test (TB test [a test to detect whether a person has been infected with TB bacteria]) Report" dated 3/14/19, indicated Resident 1 was diagnosed with active TB and was receiving treatment.

A review of Resident 1's history and physical (H/P), dated 3/16/19, indicated Resident 1 had the capacity to understand and make decisions.

A review of Resident 1's care plan, dated 3/14/19, indicated Resident 1 had TB and was undergoing treatment. The nurses' interventions indicated the staff would monitor the resident for signs/symptoms of TB, observe TB precautions, medicate as ordered, follow up with the public health department and follow directions regarding the treatment plan of care.

A review of a physician's orders, dated 3/14/19, indicated Resident 1 was to receive 300 milligrams (mg) of Isoniazid (medication to treat TB) by mouth (PO) daily (QD), 300 mg of Rifampin (medication to treat TB) PO QD, 50 mg of Pyridoxine (Vitamin B6 supplement) PO QD, Ethambutol 400 mg daily by mouth (anti-TB med), 250 mg Divalproex (medication to treat schizophrenia) PO two times daily (BID) and 50 mg of quetiapine [Seroquel] (an antipsychotic medicine that is used to treat schizophrenia) PO at bed time.

A review of Resident 1's care plan, dated 3/15/19, indicated Resident 1 was able to participate in discharge planning process. The staff's interventions included to coordinate discharge goals with rehabilitative therapies, arrange a family conference to establish discharge plan, arrange and schedule post discharge appointments and services needed, follow up with the resident/family to assure understanding of plan or answer additional questions and offer opportunity for the resident to visit the potential new home or care center.

A care plan for Resident 1, dated 3/21/19, indicated Resident 1 required assistance with bed mobility, transfer, ambulation, dressing and personal hygiene. It also indicated Resident 1 was at risk for fluctuating activities of daily living (ADLs) due to TB, muscle weakness of coordination. The staff's interventions included to assist the resident with ADLs, shower as scheduled, administer medications as ordered and observe for side effects, notify the physician of any changes in Resident 1's condition.

A review of a physician's order, dated 3/21/19 indicated to discontinue Rifampin 300 mg. QD and start 300 mg of Rifambutin PO QD due to a drug to drug interaction of Rifampin and quetiapine (an antipsychotic medicine that is used to treat schizophrenia).

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A review of a "Community Disease Control and Prevention: Tuberculosis Control Program," dated 3/13/19, indicated a recommendation for Rifampin (anti-TB medication) 300 milligram (mg) every day (QD) to be substituted with Rifambutin 300 mg QD due to a drug to drug interaction with the resident's antipsychotic medications (medication to treat mental disorders).

A review of a "Request for Monthly TB Medical Update," dated 6/4/19, indicated Resident 1 started TB treatment on 3/14/19 and the expected date of completion of therapy was unknown. It also indicated Resident 1 was currently receiving three TB medications and B6.

A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 6/20/19, indicated Resident 1 was able to understand and be understood by others. According to the MDS, Resident 1 required supervision with bed mobility and transferring from a bed, to a chair and/or standing position. The MDS indicated Resident 1 required a one-person physical assist with ADLs. According to the MDS, Resident 1 used a cane for ambulation and was receiving antipsychotic medications (medications to treat mental disorder).

A review of an article, by the Centers for Disease Control and Prevention titled, "Tuberculosis (TB)," indicated taking several medications will do a better job of killing the bacteria and preventing them from becoming resistant. The four common medications include isoniazid, rifampin, ethambutol and pyrazinamide for a minimal of six months, but nine months is recommended because TB bacteria die slowly. https://www.cdc.gov/tb/publications/faqs/qa_tbdisease.htm.

A review of the SSD's note, dated 6/18/19 indicated Resident 1 was assessed by the owner of the UALF for possible placement in the UALF and the owner accepted Resident 1 for placement in her home.

There was no documented evidence that the IDT team assessed Resident 1 for possible discharge to a lower level of care, as per the facility's policy.

A review of an untimed "Licensed Nurses Weekly Summary," dated 6/22/19, indicated Resident 1 required supervision with ADLs, eating, bathing, dressing, locomotion (movement around the facility), hygiene and transfers.

A review of a "Recapitulation (brief summary) of Care Discharge Summary/Guide for Aftercare," dated 6/24/19, completed by a registered nurse (RN 1), indicated Resident 1 was discharged on 6/24/19 to ALF ([sic] UALF), because the resident's health had “improved” per RN 1’s assessment. It also indicated Resident 1 was discharged with the following medications and amounts:12 tablets of quetiapine, 50 milligrams; 16 capsules of Gabapentin 100 mg; 10 tablets of Divalproex sodium; six (6) tablets of Isoniazid 300mg; and four (4) tablets of Rifampin 300mg. Rifampin which had been discontinued on 3/21/19 was still given to Resident 1 upon discharge, instead of Rifambutin 300 mg.

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A review of a physician's telephone order, dated 6/24/19 and timed at 9:15 a.m., indicated Resident 1 should be discharged to an assisted living (ALF) with home healthcare to follow-up.

A review of Resident 1's physician's progress notes indicated there was no documentation by the resident's physician regarding the basis of Resident 1's discharge to ALF on 6/24/19, as stipulated (specified) per the facility's policy. The nurses' progress notes and the SSD's notes had no documentation explaining the sudden need to discharge Resident 1 to a lower level of care. There was no IDT documentation to indicate they coordinated, collaborated, and planned the delivery of care to prepare Resident 1 for discharge to a lower level of care.

A review of a "Licensed Personnel Progress Note," dated 6/24/19 and timed 9:15 a.m., indicated Resident 1 was discharged and picked up by the owner of the ALF (UALF) at 11 a.m.

On 7/13/19 at 9:40 a.m., during an interview, Resident 1 stated that he did not know why the facility decided to discharge him on 6/24/19, because he did not have medications or food. Resident 1 stated, "I did not consent to the discharge and a lady just came and took me to her home and did not give me my medications or help me shower." Resident 1 stated he was readmitted to the facility on 7/12/19.

On 7/13/19 at 10:04 a.m., during a concurrent interview and review of Resident 1's clinical record (nurse's and physician progress notes and physician's orders), RN 1 stated that the SSD asked her to discharge Resident 1 to an assisted living facility. RN 1 stated she notified Resident 1's physician and received telephone orders for Resident 1 to be discharged. According to RN 1, the telephone order to discharge Resident 1 was subsequently confirmed in a text message from the physician.
RN 1 also stated that upon discharge, Resident 1 was transported to the home by the owner of the home. RN 1 stated that Resident 1 was discharged with only a few TB and psychotropic medications (any medication capable of affecting the mind, emotions, and behavior), without any plans of a physician to follow the resident's care. According to RN 1, Resident 1 required assistance in taking his medications and was not able to care for himself. RN 1 stated that failure of completing the TB treatment regimen could lead to complications including death of Resident 1.

On 7/13/19 at 10:35 a.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated that Resident 1 required assistance in taking medications because the resident was not capable of self-medicating. LVN 1 stated Resident 1's TB symptoms could exacerbate (to make worse) if the resident did not take medications as ordered. LVN 1 stated, "You don't play with TB, because it could be deadly."

On 7/16/19 at 1:03 p.m., during a telephone interview, the SSD stated that Resident 1 was assessed and cleared by the owner of the house, who was not a nurse, for discharge to lower level of care. The SSD stated the IDT did not meet to clear Resident 1 for discharge and she had never been to the home to assess safety of the home. The SSD stated she had assumed that Resident 1 could self-medicate and did not know if Resident 1 had enough medications for discharge. The SSD stated she was not aware that Resident 1

was supposed to continue taking TB medicines. The SSD also stated that no arrangements were made for a physician to follow up with the Resident 1 post discharge. According to SSD, not ensuring that Resident 1 was discharged to a place where all his needs could be met, could lead to harm and injury to the resident, as well as exacerbating (the process of making a problem, bad situation, or negative feeling worse) his TB symptoms.

On 7/16/19 at 1:30 p.m., during a telephone interview, the DON stated that the facility "dropped the ball" by not holding an IDT meeting to clinically clear Resident 1 for discharge, not notifying the public health nurse (PHN 1) of Resident 1's discharge, not providing the resident with at least a week's worth of medications, not asking a physician to continue seeing Resident 1 after discharge. The DON stated that the facility made a mistake by not assessing the ALF (assisted living facility) to ensure Resident 1's needs could be met. The DON stated that these failures could cause Resident 1's conditions to get worse.

On 7/16/19 at 1:37 p.m., during a subsequent telephone interview, RN 1 stated Resident 1 was accidentally discharged with the wrong TB medication, rifampin 300 mg, that had been discontinued. RN 1 stated that this could exacerbate the resident's symptoms because the medication was discontinued due to a drug to drug interaction. RN 1 also stated that she was not sure how the facility made the decision to discharge Resident 1 to a lower level of care because Resident 1 required assistance with ADLs and was being monitored by a PHN (PHN 1) from the Health Department for TB.

On 7/16/19 at 2:39 p.m., during a telephone interview, Resident 1's physician (MD 1) stated that he was shocked to find out from PHN 1, after PHN 1 had been looking for Resident 1, that the facility had discharged the resident to a lower level of care. MD 1 stated that Resident 1 could not make decisions due to his cognitive (thought process) impairment, was not stable for discharge and required assistance with all activities of daily living, including taking his medications. MD 1 stated that he did not give discharge orders. According to MD 1, Resident 1 was readmitted to the facility on 7/12/19, as soon as he found out the resident was inappropriately discharged.

On 7/18/19, at 10:49 a.m., during a telephone interview, the owner of the UALF stated that it was a private home, not an assisted living as indicated by the facility. The homeowner stated that she rents rooms out in her homes to cover her mortgage payments and that the facility's SSD was aware. The homeowner stated that she was not a nurse, was untrained in patient care and does not administer medications nor provide assistance with ADLs to her tenants. The homeowner stated that the SSD told her that Resident 1 was independent and only needed a place to live. The homeowner stated, the name she calls her home might indicate it was an assisted living facility but it was not. She stated, "I chose the name for my homes just because it sounded nice…" not because I provide any type of nursing services."

On 7/18/19, at 11:16 a.m., during an interview, PHN 1 stated that Resident 1 was discharged inappropriately without ensuring the resident had enough medications for TB and mental disorders, as well as follow-up care for TB. PHN 1 stated that the facility did not notify her about Resident 1's discharge and did not provide an ongoing physician care. PHN 1 stated that Resident 1 did not take his medications for 18 days after being

discharged from the facility and stated not taking TB medications could exacerbate Resident 1's condition and prolong the TB treatment.

A review of a "Request for Monthly TB Medical Update" form completed by the PHN, dated 7/25/19 indicated Resident 1 was discharged and was not taking his TB medications during that time (6/24/19 through 7/12/19), for a total of 18 days.

b. A review of Resident 2's Admission Face Sheet indicated Resident 2, was a 29 year-old female, who was admitted to the facility on 2/1/19 with a recent readmission on 4/1/19. Resident 2 had diagnoses that included an immunocompromised disease (a person does not have the ability to respond normally to an infection due to an impaired or weakened immune system), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and schizophrenia (chronic and severe mental disorder that affects how a person thinks, feels, and behaves).

A review of an H/P, dated 2/1/19, indicated Resident 2 had the capacity to understand and make decisions.

A review of Resident 2's care plan, dated 2/1/19, indicated Resident 2 required assistance with bed mobility, transfer, ambulation, dressing, eating, personal hygiene and bathing related to lack of safety awareness and poor personal hygiene. The staff's interventions indicated to assist Resident 2 with ADLs, provide clean clothing to wear, keep groomed in appearance, maintain good personal hygiene and neat appearance, set up grooming supplies as needed, administer medications as ordered and shower the resident as scheduled.

A review of Resident 2's care plan dated 2/1/19, indicated Resident 2 was at risk for injury to self or others related to his schizophrenia diagnosis. The staff's interventions included to determine triggers and de-escalation (slowing down an encounter by "backing off" from immediate intervention or action) techniques, minimize environmental stressors, provide a calm, quiet and supportive environment.

A review of Resident 2's physician orders, dated 2/1/19 indicated Resident 2 was receiving medications for the immunocompromised disease and depression (Remeron 15 mg and Wellbutrin 100mg by mouth every night).

A review of Resident 2's MDS, dated 2/7/19 indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required staff's assistance with bed mobility, transferring from a bed, chair to a standing position, moving from one location to another, dressing, eating, toilet use and personal hygiene. According to the MDS, Resident 2 used a walker for mobility and was receiving antipsychotic and antidepressant medications (medications to treat depression).

A review of Resident 2's Licensed Nurse Weekly Summary, dated 3/21/19, indicated Resident 2 required supervision with bathing, locomotion and hygiene.

A review of an untimed SSD's note, dated 3/28/19, indicated Resident 2 was assessed for placement by the homeowner of the UALF with plans to be discharged there on 4/1/19.

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A review of Resident 2's Licensed Progress Note, dated 3/28/19 and timed at 12 p.m., indicated Resident 2 had an order from the resident's physician to be discharged to an ALF.

A review of an untimed progress note, dated 4/1/19, indicated Resident 2 was discharged to the ALF (UALF).

There were no IDT notes in Resident 2's clinical record indicating Resident 2 was evaluated for discharge, as per the facility's policy.

A review of Resident 2's untimed Discharge Summary Record, dated 4/1/19, indicated Resident 2 required assistance with walking, bathing and toilet use. This record indicated Resident 2 was discharged to the UALF with limited amount of medications.

On 8/7/19 at 10:41 a.m., during a concurrent interview and record review, the DON stated that Resident 2 was discharged on 4/1/19 to the UALF. The DON stated that facility did not hold an IDT meeting to clinically evaluate and clear Resident 2 for discharge. The DON also stated without assessing Resident 2, the facility would not know if the resident's needs could be met at UALF. According to the DON, Resident 2 had to be adequately prepared for discharge and information provided on where the resident could continue to get medications. The DON stated that the facility should have also ensured Resident 2 had a physician for post discharge follow-up and addresses of where the resident could go for help.

c. A review of Resident 3's Admission Face Sheet indicated Resident 3 was a 55 year-old female, who was admitted to the facility on 3/15/19 with diagnoses including diabetes mellitus ([DM] high blood sugar), anxiety (uneasy feeling), bipolar disorder (a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks) and schizophrenia.

A review of Resident 3's physician's orders, dated 3/15/19 indicated Resident 3 was to receive Metformin (an oral diabetes medicine that helps control blood sugar levels) 1000 mg PO BID with meals for DM, finger stick blood sugar monitoring before meals and at bed time, with administration of insulin as needed (insulin helps keep blood sugar levels from getting too high (hyperglycemia). Depakote (used to treat certain psychiatric conditions [manic phase of bipolar disorder]) 500 mg PO BID (twice a day) for bipolar disorder and Latuda 40 mg PO BID with meals for schizophrenia.

A review of Resident 3's undated care plan indicated Resident 3 was receiving psychoactive medications (medications to treat mental disorders). The staff's interventions included to monitor and record episodes Resident 3's behavior, administer medications as ordered and monitor for medication side effects.

A review of Resident 3's care plan, dated 3/15/19, indicated Resident 3 required supervision with bed mobility, transfer, ambulation (walking), toilet use and bathing. The staff's interventions included to assist with all ADLs, provide clean clothing to wear, keep groomed in appearance, administer medications as ordered and observe for side effects.

A review of Resident 3's H/P, dated 3/17/19, indicated Resident 3 had the capacity to understand and make decisions.

A review of Resident 3's MDS, dated 3/22/19 indicated Resident 3 required a one-person physical assist with bed mobility, transferring from a bed, chair to a standing position, moving from one location to another, dressing, eating, toilet use and personal hygiene. According to the MDS, Resident 3 used a wheelchair for mobility and was receiving antipsychotic medication.

A review of Resident 3's Licensed Nurse Weekly Summary, dated 4/3/19 indicated Resident 3 required limited assistance in bathing, dressing and hygiene. These notes also indicated Resident 3 required supervision with locomotion and transfers.

A review of a SSD's untimed note, dated 4/5/19, indicated Resident 3 was assessed by the owner of the UALF for placement in the UALF with plans for discharge on 4/10/19 to the UALF.

A review of an untimed nurse's note, dated 4/10/19, indicated Resident 3 was discharged to the UALF.

There was no documented evidence in Resident 3's clinical record that an IDT meeting was conducted to assess if the resident was clinically stable to discharge to a lower level of care prior to discharge, as per the facility's policy.

On 8/7/19 at 10:34 a.m., during a concurrent interview and record review, the DON stated that Resident 3 was discharged on 4/10/19 to the UALF. The DON stated that the facility did not have an IDT meeting to clinically evaluate and clear Resident 3 for discharge, as per the facility's policy. The DON also stated without assessing Resident 3, the facility would not know if the resident's needs could be met at the UALF. The DON agreed that the facility did not adequately prepare Resident 3 for discharge because no information was provided to Resident 3 on where the resident could get medications and/or which physician would follow up with the resident's care.

d. A review of Resident 4's Admission Face Sheet indicated Resident 4 was a 51 year-old male, who was admitted to the facility on 1/17/19 with a most recent admission on 5/3/19. Resident 4 had diagnoses including ESRD receiving dialysis (process of removing toxins and waste from the blood using a machine) treatment, major depression, generalized muscle weakness and lack of coordination.

A review of Resident 4's H/P, dated 2/28/19 indicated Resident 4 had the capacity to understand and make decisions.

A review of Resident 4's care plan, dated 2/28/19, indicated Resident 4 required assistance with bed mobility, transfer, ambulation, toilet use and bathing, due to poor physical endurance, and ADL self-performance and support fluctuated on a daily basis. The staff's interventions included to assist with ADLs, provide clean clothing to wear, keep groomed in appearance, administer medications as ordered and observe for side effects.

A review of Resident 4's Licensed Nurse Weekly Summary, dated 4/26/19 indicated

Resident 4 required supervision with eating, bathing, dressing locomotion, hygiene and transfers.

A review of Resident 4's MDS, dated 4/27/19 indicated Resident 4 was able to understand and be understood by others. According to the MDS, Resident 4 required one-person assistance with bed mobility, transferring from a bed, chair to a standing position, moving from one location to another, dressing, eating, toilet use and personal hygiene.

A review of a nurse's progress note, dated 5/3/19 and timed at 10 a.m., indicated Resident 4 would be discharged to the UALF. A review of another progress note, on the same date, timed at 4:15 p.m., indicated Resident 4 left the facility with all his belongings.

A review of Resident 4's clinical record, indicated there was no documented evidence that an IDT was conducted indicating Resident 4 was ready and prepared for discharge.

On 8/7/19 at 10:43 a.m., during a concurrent interview and record review, the DON stated that Resident 4 was discharged on 5/3/19 to the UALF. The DON stated that facility did not have an IDT meeting to clinically evaluate and clear the resident for discharge. The DON stated this could result in harm to the resident.

On 8/7/19 at 10:47 a.m., during an interview, the SSD stated that she failed to visit and check out the UALF prior to discharging Residents 1, 2, 3, and 4. The SSD stated that there was no IDT meeting done to clinically evaluate the residents for discharge clearance and/or a physician contacted for ongoing care of residents after discharge. The SSD stated that not having a physician to follow the residents post discharge could worsen the residents' medical conditions and result in harm to the residents.

On 8/8/19 at 4 p.m., during an interview, the AIT (administrator in training) stated she visited the UALF on 8/7/19 and the homeowner of the UALF stated Residents 3 and 4's whereabouts were unknown and she would not tell him any pertinent information of their location.

A review of an Employee Termination Record, dated 8/12/19, indicated that the facility fired the SSD, effective 8/8/19 due to violation of known facility rule or policy. The narrative indicated that the SSD discharged patients without an IDT meeting to an unsafe location without proper documentation and without determining the ability of the accepting facility to administer medications to the residents.

A review of the facility's policy titled, "Discharge Summary and Plan," with a revised date of 11/2014, indicated when a resident's discharge was anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his or her new living environment. The policy also indicated a post discharge plan would be developed by the IDT team with assistance of the resident and his or her family. According to this policy, the SSD would review the plan with the resident and family within twenty-four (24) hours before discharge takes place, and a copy of the plan filed in the resident's medical records.

A review of the facility's policy titled, "Discharging the Resident," with a revised date of

11/2012, indicated the purpose of the policy was to provide guidelines for the discharge process. The policy indicated the resident would be consulted about the discharge, with information regarding who would provide resident's care.

A review of the facility's policy titled, "Transfer or Discharge Documentation," with a revised date of 8/2014, indicated when a resident was transferred or discharged, the details of the transfers or discharges would be documented in the medical records and a summary of the resident's overall mental, physical and medical condition. The policy also indicated the reason for the transfer or discharge would be documented in the resident's clinical records by the resident's attending physician.

The facility failed to implement its policies and the residents' plan of care for Residents 1, 2, 3, and 4, who required assistance with care. Residents 1, 2, 3, and 4 were discharged to an UALF without evaluation to determine whether the residents were clinically stable for discharge to a lower level of care and whether placement in the UALF would be safe and appropriate. The facility's deficient practices included:

1. Failure to implement its policy titled, "Transfer or Discharge Documentation," indicated when a resident was transferred or discharged, the details of the transfers or discharges would be documented in the medical records and a summary of the resident's overall mental, physical and medical condition and the reason for transfer documented in clinical records by the attending physician to determine if the discharge was appropriate for Residents 1, 2, 3 and 4.

2. Failure to ensure Resident 1, who was diagnosed with active TB and was being followed by the Health Department, was discharged to a lower level of care with the approval of his physician and an adequate amount of TB medications.

3. Failure to adhere to Resident 1's care plan that stipulated the staff would coordinate discharge goals with rehabilitative therapies, arrange a family conference to establish discharge plan, arrange and schedule post discharge appointments and services needed, follow up with the resident/family to assure understanding of plan or answer additional questions and offer opportunity for the resident to visit the potential new home or care center.

These deficient practices resulted in Resident 1 being discharged to an unlicensed home without any care givers and not receiving TB medications for 18 days. Residents 2, 3, and 4, all of whom required assistance with care and medication administration, with Resident 4, who had ESRD requiring transportation to dialysis treatment three times a week, were also transferred to an UALF and later discharged. The owner of the home refused to provide the whereabouts of Residents 3 and 4.

The above violations presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical or mental harm would

result for Residents 1, 2, 3, and 4.

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