STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105428	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mariam Health and Rehabilitation Center	1801 N Lake Mariam Dr Winter Haven, FL 33884

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews and record review, the facility failed to ensure resident spaces, and resident equipment were clean/sanitary and maintained to include Soiled Air Conditioner unit filters; Soiled walls; Soiled ceiling tiles; Soiled bathroom equipment, Soiled walls and doorways on two of two floors and within two of four halls (100 and 200). Findings included: On 10/7/2024 at 9:08 a.m., 11:00 a.m. and 1:45 p.m., The facility was toured with the following findings. The first floor dementia unit to include resident rooms 101 - 134 revealed: 1. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. 2. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. The baseboard on the right side of the PTAC unit was observed waterlogged and peeled off the wall, leaving a gap between the plastic baseboard and the wall. The shared bathroom was observed with floor material peeled up and leaving a trip hazard, and also was not a cleanable surface. 3. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. The baseboard in the shared bathroom right side observed peeled and leaving hole and gap between the baseboard and wall. 4. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. A spotted black colored biogrowth was observed behind the main room door on the door frame. The shared bathroom was observed with cracked and missing floor tiles at the base of the toilet leaving a non cleanable surface. 5. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. The shared bathroom was observed with a grey metal over the commode seat. All four legs and the metal cross connectors were observed with heavy paint peeling with heavy rusting. (continued on next page)

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. 7. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. Also, one ceiling tile was observed heavily waterlogged, posing recent water damage. 8. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. Also, observed black biogrowth on the wall on the right side of the a/c PTAC unit. 9. Resident room [ROOM NUMBER] was observed with a hole in the wall on the baseboard on right side of the PTAC unit. 10. The 100 unit Dining room/Activity Solarium room, which was frequented by over 8 residents each time of observation, was observed with heavy wet appearing black biogrowth on four ceiling tiles near the television and at the back of the room. 11. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. The floor baseboard on the right side of the PTAC unit was peeled up and with water damage. 12. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. 13. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. There was also black biogrowth on the wall at and near the PTAC power plug-in plate/area. 14. Resident room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. 15. room [ROOM NUMBER] was observed with a window wall mounted Packaged Terminal Air Conditioner PTAC unit with heavy caked-on dust debris on both filters. There was also Ceiling water damage on ceiling above window bed. The second main floor was observed with the following: 16. The main hallway ceiling near the 200 unit nurse station, which is frequented by residents, was observed with a metal ceiling vent with black biogrowth spotting as well as heavy rusted areas. The rusted areas were not cleanable. 17. The ceiling above the 200 unit station was observed with a metal ceiling vent with black biogrowth spotting as well as heavy rusted areas. The rusted areas were not cleanable. 18. The main hallway outside resident room [ROOM NUMBER] was observed with a metal ceiling vent with black biogrowth spotting as well as heavy rusted areas. The rusted areas were not cleanable. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. The main hallway outside resident room [ROOM NUMBER] was observed with a metal ceiling vent with heavy black biogrowth spotting as well as heavy rusted areas. The rusted areas were not cleanable. 20. The main dining room was observed with a tray ceiling. The metal ceiling vent and extended ceiling area above the door leading to the education room, was observed with black and grey colored dirt/debris. The air vent blows directly into the dining room and was above two tables where residents dine and sit. 21. The Education room, which was located on the other side of the door from the main dining room, revealed two sets of doors that led to the outside porch. The outside porch was utilized for residents to sit at and there were four residents and a staff member seated out in this porch. Two of the doors on the inside of the building were noted with heavy blotches of black biogrowth. 22. The 200 unit smaller dining room/activity room was observed with three recently water logged and still wet ceiling and air duct tiles. Many residents were observed in this room during the times of the observations. Also, a metal ceiling vent with black biogrowth spotting as well as heavy rusted areas. 23. The therapy department gym was observed with four recently water logged ceiling tiles and two metal air conditioner ceiling vents with black biogrwoth and heavy rusted areas. Photographic evidence obtained. On 10/17/2024 at 10:02 a.m., Staff I, who was the interim Housekeeping Director was interviewed with relation to Housekeeping cleaning and maintenance services. Staff I revealed she has just taken over as interim Housekeeping Director yesterday on 10/16/2024, as the previous Housekeeping Director was terminated. Staff I did confirm she has been employed at the facility as a Houskeeper for almost two years. She revealed she knows the layout of the facility and proceeded to talk about what a Housekeeper staff's responsibilities were. She proceeded to say on a daily basis staff are to go into residents spaces to include resident rooms and bathrooms and they clean high touch surfaces to include light switches, call light buttons, hand rails on beds, door knobs, A/C PTAC plastic covers, television remotes, etc. She also revealed staff are to change out the trash cans, wipe down tables and furniture, clean the entire bathroom to include floor, walls, toilet and sink. Staff I revealed housekeeping staff use a long stick sweeper to clean ceiling vents in the rooms as well. She also indicated staff sweep and mop the floors and clean the windows that look outside. She revealed housekeeping staff are not responsible for changing the air filters in the PTAC units. Staff I revealed since she had just taken over as interim Housekeeping Director, she did not know where the paper schedules and procedures were located. mmmmmm (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews with Housekeeping staff at 1:00 p.m. to include Staff I, J, K and L all confirmed their duties as indicated above from interview with Staff I. Staff J, K and L all revealed they feel they are provided with sufficient supplies to do their job however, they felt they could receive more education and inserivces in order to perform their duties with regards to cleaning black biogrowth. Staff I, J, K, and L all revealed that they have seen areas in residents spaces that looked like mold-like substances and did not know how to appropriately clean those areas. Staff I, J, K, and L all revealed once they see areas that appear to be mold-like they report it to maintenance department by way of electronic reporting work order system or by way of word of mouth. Staff I, J, K, and L all revealed that once those areas are reported, it was found that the Maintenance Director would clean off those mold-like areas. They did not know how he cleaned the areas not did they know what type of cleaning agent he used. They all felt the reported areas would be taken care of quickly. Housekeeping staff I, J, K and L could not remember if they had ever received any complaints from residents or visitors with regards to mold-like debris. Staff I, J, K, and L all revealed they felt safe in the building and they have not observed or smelled areas with must or mold-like odors. On 10/27/2024 at 10:35 a.m. an interview was conducted with the Maintenance Director. He revealed he was at the time the only person who handles maintenance issues in the building. He revealed that management was in the process of hiring another employee to add to his department. The Maintenance Director revealed he had been employed at the facility as the Maintenance Director for over a year. He was asked how he handles electronic and word of mouth maintenance work orders. He revealed he reviews the electronic work orders on a daily basis and will do correction based on priority. He revealed the work orders that are put in word of mouth, he will put in electronically so they are documented. He revealed he will try and correct each issue timely, but there are times when he has to order parts or get additional help to correct the issue. The Maintenance Director was asked who was responsible for cleaning and maintaining the resident room wall mounted air conditioner PTAC units. He explained that Housekeeping staff will clean the outside cover and buttons and maintenance department is responsible for cleaning and replacing the air filters. He revealed he will try to clean the PTAC unit air filters at least once a month. He was not able to show paperwork/documentation of this expectation. He was also not able to provide evidence that he had cleaned or replaced PTAC unit air filters the past three months as requested. The Maintenance Director revealed since he was the only maintenance staff in the building, some tasks have not been completed in a timely manner. He was shown photographic evidence of soiled PTAC unit air filters and he confirmed he had not gotten to them yet and that they should not be caked with dust/debris. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Maintenance Director denied any mold in the building. He revealed that if he, or any of the facility staff observe and report black biogrowth suspected as mold, he will immediately go to those areas and assess it. He revealed if he does not think the areas are mold, he will clean with a detergent the area and then housekeeping will continue to clean the areas after that. He revealed if he had suspected mold, he would report to the Nursing Home Administrator and Regional Maintenance Director of that suspicion and the facility has a contacted service to come out and assess and remediate the suspected mold areas. The Maintenance Director revealed since his employ, he has not observed or had any staff report to him of mold, but he has been reported of mold-like biogrowth. He revealed he had cleaned those areas and then brushed on surface of mold killing paint product called, KILZ. He revealed he spreads out this product for preventative maintenance and to keep mold like substances away. The Maintenance Director was unable to confirm how he would identify mold-like substances that would need to be reported as to opposed to just black biogrowth areas that he cleans himself. The Maintenance Director did not have any paper documentation or electronic documentation to support cleaning of black biogrwoth or mold-like substances within the last three months as per request. Further, the Maintenance Director had no current work orders to support evidence that any of the above mentioned areas were in the process of correction. On 10/17/2024 at 3:00 p.m. an interview with the Nursing Home Administrator was not aware of any mold-like substances in the building and that no staff had reported to her of this suspicion. She further confirmed the Maintenance Director would handle suspicion of mold and they have an outside sourced company that would come out and assess and remediate if need. She was not able to provide any documentation to support what the process would be if suspected mold like substances in the building. On 10/17/2024 at 3:00 p.m. the Nursing Home Administrator provided the Safe and Homelike Environment Policy and Procedure with a revision date of 4/11/2023, for review. The policy showed; In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Definitions included but was not limited to: Environment refers to any environment int the facility that is frequently that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patio, therapy areas and activity areas. Sanitary includes, but not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to: equipment used in the completion of the activities of daily living. On 10/17/2024 at 3:00 p.m. Staff I and the Nursing Home Administrator could not provide a Housekeeping and Maintenance department policy and procedure for review.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43453 Based on interview and record review, the facility failed to provide a copy of the transfer and discharge notice to the Office of the State Long-Term Care (LTC) Ombudsman for one (#1) of three residents reviewed for transfer and discharge rights. Findings included: Review of the Admission Record revealed Resident #1 was originally admitted to the facility in February of 2024 with diagnoses to include unspecified dementia without behavioral disturbance, major depressive disorder, and generalized anxiety disorder. Review of Resident #1's Nursing Home Transfer and Discharge Notice revealed the notice was given on 8/4/24. The location to which Resident #1 was transferred to was the county jail. The address and phone number were not listed. Under reason for discharge or transfer, none of the boxes were checked. Under brief explanation, the form showed, Resident incarcerated. The area to show that the notice was given to the Local Long Term Care Ombudsman Council was incomplete/blank. Review of a document titled [Name of Facility], and the facility's social services phone number, showed a list of resident names for the Ombudsman discharge notifications dated 08/02/24 to 08/31/24. This list did not include Resident #1's name and there was no entry on 8/4/24 the day Resident #1 was discharged . On 10/17/24 at 2:14 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated the discharge process included a documented discharge note, a discharge summary and the notification to the Ombudsman. She stated she normally notified the Ombudsman of discharges through an electronic fax on the first of each month. She stated she had emails to confirm the notifications. The SSD stated she did not notify the Ombudsman of Resident #1's discharge, because she only notified the Ombudsman of hospital transfer discharges and any planned discharges. She stated she did not notify the Ombudsman if a resident's transfer was unplanned. She stated she did not have transcripts confirming the receipt of the faxes the last three months. She stated the facility's IT (Information Technology) department deleted their emails after every 30 days. The SSD stated she did not have confirmation of the paperwork being faxed. Review of a facility policy titled, Discharge Planning Process, implemented 11/3/20, did not show expectations regarding Ombudsman notifications of the facility's transfers and discharges.

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F 0624 Level of Harm - Actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on record review and interviews, the facility failed to ensure a safe an orderly discharge and appropriately document in the medical record the events and follow through of the discharge for one resident (#1) who was transferred to an inappropriate location following an emergent incident between Resident #1 and another resident of three residents reviewed for transfer and discharge rights. Findings included: Review of the Admission Record for Resident #1 showed the resident was initially admitted to the facility on [DATE] with admitting diagnoses to include: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety; major depressive disorder, recurrent, moderate; generalized anxiety disorder; other specified persistent mood disorders; nicotine dependence, cigarettes, uncomplicated. The Admission Record showed Resident #1 was discharged from the facility on 08/04/2024. Review of a Determination of Incapacity signed by the resident's attending physician on 02/24/2024, revealed the physician evaluated and determined Resident #1 lacked the capacity to give informed consent to make medical decisions and does not have reasonable medical probability of recovering mental and physical capacity to directly exercise rights. Review of an Administration Note, dated 8/5/24 at 00:42 (12:42 a.m.), showed Increase to one on one supervision due to behaviors, every shift. Resident out of facility taken by police. Review of an Administration Note, dated 8/5/24 at 3:52 (a.m.), showed Resident out of facility. resident escorted by police out of facility. A review of a social service note, dated 8/5/24, revealed SS (social services) assisted the assistant administrator with a resident to resident. SS called the [Local Police Department] and advised them we had a Res. To Res. In our memory unit and both residents were incapacitated. The assistant administrator notified SS that the resident had been arrested. SS immediately got in contact with [Local Police Department], and they notified the officer to writer back immediately. The officer that responded to the altercation did call back and at that moment I 3-way [Staff Name] in as we were previously on the phone together. The officer said when he arrived at our facility, he asked multiple times if the resident was incapacitated, and the nurses responded no multiple times. The officer mentioned he knows our facility and he knows our downstairs unit very well this is why he asked multiple times about the resident's capacity. He took the nurses words on no capacity in place. The Officer also stated he had on his body cam footage the resident admitting what she had done and said if she could have hit the other resident, she would have done that. She explained in detail to the officer what she had done. SS will assist where needed. A review of Resident #1's electronic medical revealed the resident was arrested on 08/04/2024, by the [Local] Police Department, after an altercation with another resident in the facility. Resident #1 was charged with Battery on Person [AGE] years of Age or Older. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	Review of an Order Granting Pretrial Release for Resident #1, dated 08/05/2024, revealed the Circuit/County Judge ordered Resident #1 may return to the residence listed on affidavit but must stay on a separate floor. Review of a psychiatry subsequent note, dated 8/5/24, revealed, Resident #1 was unstable and required a psychiatric assessment. As per collected information, DON (Director of Nursing) requested patient be seen due to having an altercation with another patient. Patient states another patient called her a [explicative] So she pushed them. Discussed not touching people and talking with staff. Patient verbalized understanding. No addictive substances cravings. No other psychiatric symptoms noted. No side effects to current psych meds (medications) were reported. Dementia is persisting, but no other behaviors noted. On 10/17/2024 at 11:25 a.m. an interview was conducted with the Social Services Director (SS). She stated Resident #1 was physically aggressive, but not all of the time. She said the behaviors happened more when Resident #1 was initially admitted to the facility because she wanted to smoke. She said the resident would say that she wanted to leave the facility. Resident #1 was deemed to be an elopement risk. The resident was sharing a room with her spouse, and the SS said the facility created a space outside for the resident, so she could smoke. The SS stated Resident #1 did not have behaviors anymore. She enjoyed hanging out in the courtyard with her spouse and drink coffee. The SS said normally when the police are called and the resident is in the memory unit, the resident is [emergency transfer] and not arrested. Resident #1 was housed in the memory care unit and had a dementia diagnosis. The SS said Resident #1's arrest was a result of the police officer deciding to arrest Resident #1 after she pushed the other resident down and admitted it. She said that corporate would not allow Resident #1 to return to the facility after the arrest. An interview was conducted on 10/17/2024 at 12:19 p.m. with the Director of Nursing (DON). The DON confirmed she could not find any progress notes related to discharge planning or finding alternative placement for Resident #1. The DON also confirmed Resident #1's discharge care plan had not changed during the resident's stay in the facility. At this time the Assistant Nursing Home Administrator (ANHA) stated the SS called the police and the police spoke to the nurse (Staff A, Registered Nurse). The nurse said he was passing meds in the solarium area and heard Resident #1 yelling out loud and was standing next to the other resident. She stated she pushed the other resident because he called her a [explicative]. The other resident was on the floor on his right side with his wheelchair turned over. The nurse called the DON and the residents were immediately separated. We placed a psych consult and the nurse stated at that point the police arrived. The police decided to do an arrest at this time. An attempt to contact Staff A, RN who was involved in the incident was made and no return call was received during or post survey. 43453 (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	- The resident has a behavior problem aggression towards other residents r/t (related to) does not like others to enter her or [spouse's] personal space. Controlling/Verbally & Physically tries to break things. Behaviors throwing things exit seeking more. Refuses Showers (initiated 6/14/24, cancelled 8/7/24). Goal was the resident will have fewer episodes by review date. Interventions included administer medications as ordered, increase to one on one supervision due to behaviors, initiated on 8/4/24; intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, initiated 6/14/24; monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. - [Resident #1] is at risk for elopement/exit seeking actively exit seeking. Actively verbalizing desire to leave & has the means to do so. Agitation, aimless wandering due to cognition, has the potential to approach exit doors. History of elopement. Sent to hospital/ER (emergency room) r/t - aggressive behaviors trying to break window with w/c (wheelchair), disruptive behaviors, cursing, yelling, threaten remarks unable to re-direct; police here and took [Resident #1] out of facility: due to her pushed down another resident. She was redirected and spoken to and 15 min checks for observation and behaviors was in place; initiated 3/1/24. Goal was for Resident #1 to not leave the facility unattended through the review date. Interventions included: 15 minute checks on night shift & 1:1 supervision on day and evening shifts for safety, initiated 7/8/24 - Focus Area - [Resident #1] has the following behavior problem(s) restlessness/pacing. [Resident #1] has hx (history) of placing self on floor, refusing care and medication, initated on 2/28/24 and resolved on 5/29/24. An interview was conducted on 10/17/2024 at 1:14 p.m. with the SS and Assistant Nursing Home Administrator (ANHA). and she stated the facility could not accept Resident #1 back to the facility because she would have required 1:1 supervision. The ANHA stated Resident #1 was physically and verbally aggressive, however, she could not confirm another specific incident other than the incident when Resident #1 was arrested. Review of a progress note, dated 06/13/2024, for Resident #1 revealed the resident was taking smoke breaks, and she stated upon entering her room, her bed was occupied by a resident from another room. Resident #1 woke up the resident in her bed and he attempted to kick her, she called for help, the hall monitor entered the room and redirected the intruding resident to his room. Review of a Social Service progress note, dated 07/09/2024, showed a care plan meeting was held with the team and Resident #1's daughter. No new concerns noted at the time. Review of a progress note, dated 07/17/2024, for Resident #1 revealed the resident continues on 1:1 monitoring with Certified Nursing Assistant (CNA) at bedside. The resident was calm and resting peacefully at that time. Review of a progress note, dated 07/21/2024, for Resident #1 showed the resident remained safe with no behavioral issues throughout the shift with 1:1 at bedside. Review of a progress note, dated 07/26/2024, for Resident #1 showed the resident was observed down the hall with 1:1. The resident was alert with no obvious distress noted, due to meds given as prescribed. No agitation noticed throughout the shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105428	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mariam Health and Rehabilitation Center	1801 N Lake Mariam Dr Winter Haven, FL 33884

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F 0624 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note, dated 07/30/2024, for Resident #1 showed the resident was on checks every 15 minutes, resident was observed in her room resting, smoke break was provided as needed, no obvious distress noted at that time. A follow-up interview was conducted on 10/17/2024 at 3:58 p.m. with the ANHA and she said it was not her decision to not allow Resident #1 to be admitted back to the facility. She said it was a corporate decision. She agreed the facility did not document the reasons why Resident #1 could not be readmitted to the facility. The ANHA confirmed if a resident's plan of care changed it should be documented in the resident's chart. No documentation was done by the facility indicating the discharge care plan changed for Resident #1. The ANHA stated if Resident #1 had increased behaviors which impacted her residency in the facility these behaviors should have been documented in the resident's chart. The ANHA confirmed she was aware Resident #1 was granted court approval to return to the facility. She re-stated it was not her decision to deny readmission to Resident #1. Review of the facility's Discharge Planning Process Policy, dated 11/3/2020 and revised 9/19/2023, revealed: Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Definitions: Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. Procedure: 1. The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge. 2. The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle, and as needed. (a) Initial information and discharge goals will be included in the resident's baseline care plan. (b) Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care. 3. If Discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why. (continued on next page)

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