STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interviews, and policy review the facility failed to ensure resident representatives received complete discharge notices timely and failed to notify the state health department of resident discharge. This affected five residents (#58, #59, #60, #61, and #62) of five residents reviewed for discharge from the facility's secured unit. Findings included: 1. Review of Resident #58's closed medical record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type, Alzheimer's, intermittent explosive disorder, conduct disorder, unspecified dementia, noncompliance with medication regimen, behavior pattern, wandering disease, age-related cognitive decline, and need for assistance with personal care. Review of Resident #58's physician orders dated 04/21/25 revealed ok to discharge to long-term care facility. Review of Resident #58's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident was discharged to a nursing home (long-term care facility). Review of Resident #58's social service note dated 04/10/25 revealed the ombudsman questioned social services about issuing a 30-day notice. The noted identified the facility had no knowledge or intent of issuing a 30-day notice. Review of Resident #58's nurses note dated 04/15/25 revealed Resident #58's representative was notified that the memory unit would be closing in 30 days. The Medical Director would be in to evaluate the resident to determine if the resident was safe to reside in the facility. The representative indicated she would like the resident to be sent to the floor if possible after the doctor's evaluation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's physician note dated 04/15/25 and signed 04/17/25 revealed the resident was an [AGE] year-old male being evaluated for his dementia. The facility had given residents and family a 30-day notice that the secured unit will be closing. The resident was not suitable for the main floor. He was at high risk for elopement and also had a history of aggressive behaviors and agitation. He was out on the main floor for a brief period and had to be put on a secure unit. He was unsafe for him and others. Daughter was present at bedside. She would like a referral to a facility closer to where she lives. The physician indicated she had given the information to staff. Patient was asleep. She states he slept most of the day today. When trying to awaken he did get agitated, but she was able to redirect. The resident does have severe cognitive deficit and cannot answer simple questions. He was resting comfortably when not being bothered. She had concerns at he was given a diagnosis of schizoaffective disorder. This was before he was admitted to our facility by psychiatry. The physician identified he felt his main issue was his dementia with behavior disturbance. We can have psychiatry re-evaluate if needed. Will continue medicines at current levels. Continue to encourage good oral intake. Redirect as needed. Continue medicines at current levels. Psychiatric services can follow as needed. Review of an undated letter addressed to Resident #58's representative revealed the facility was initiating a 30-day written discharge notice. The letter included that on 04/15/25 that you were notified in person or via telephone that on 05/16/25 the Memory Care unit would be closing. All residents residing on the memory care unit were evaluated by the medical director on April 15th (2025) to determine if the resident was appropriate to be moved to the floor or if due to safety concerns they needed different levels of care. The Social Service Designee (SSD) would continue to work with you to place the resident in an appropriate setting. If you have any concerns, please call me. Please see the attached discharge notice. At the bottom of the letter the State Long Term Care Ombudsman office email was provided along with the Regional, however there was no evidence on how to appeal the discharge. Review of Resident #58's discharge notice undated revealed on 04/15/25 that the resident would be discharged from the facility. If the information in this notice changes prior to the actual transfer or discharge date d, we will update the recipients of this notice. The discharge location and date were left blank. The reason for the discharge was the welfare and needs of the residents cannot be met in the facility. The local Ombudsman number was provided and the email section indicated to see attachment. There was no evidence mailing and/or email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder in the notice. The notice indicated that a copy of the notice would be sent to the State Health Department and State Long Term Care Ombudsman. There was no evidence that a copy of the discharge order was sent with the discharge notice. The discharge notice was difficult to read due to it having been re-copied and some areas were darkened and not very legible, random lines running through the notice, and wording was blurry. Review of Resident #58's nursing note dated 04/21/25 revealed the resident was being discharged to another facility. The representative transported the resident to the new facility. The nurse attempted to have the representative sign discharge papers several times and she refused and reported she spoke to her lawyer and stated she didn't have to sign any papers. The discharge paperwork and notice of transfer paper were not signed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a copy of a certified letter receipt undated revealed Resident #58's family received a letter on 04/23/25. Interview on 05/05/25 at 11:40 A.M., with Resident #58's representative revealed the SSD was not very helpful in assisting with finding new placement. The transfer was very quick, and she didn't have much time to prepare. The representative reported she did receive three letters, however two indicated to see the attached discharge notice and there was no attachment included. The representative could not recall if the third letter sent included the appeal process but there was more than the one-page letter. The representative reported the discharge ended up being a positive change and her father was doing much better. Interview on 05/05/25 at 11:29 A.M. and 05/06/25 at 9:59 A.M., with SSD #56 revealed the discharge notice indicated the state health department would be notified of the discharge however he did not send a copy to the state health department. SSD #56 reported originally he notified residents representatives via phone or in person on 04/15/25 of the closure of the memory care unit. On 04/16/25 after speaking to the Ombudsman he sent the 30-day notice letter out to all representatives via regular mail and then later that day he sent the same letter out via certified mail. He did not include the attachment (discharge notice) per the letter with the first two letters he sent, so he sent a third certified letter out to include the discharge notice around or on 04/18/25. SSD #56 confirmed the discharge notice did not include all the required information (date and location of discharge or advocate information for residents with a mental health disorder). The SSD #56 confirmed he did not send out a revised discharge notice with location and date of discharge to the representative. Four of the five residents that were discharged to the same facility (40 minutes away) and the fifth resident was discharged to a facility down the road. 2. Review of Resident #59's closed medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, depression, need for assistance with personal care, and history of falling, urinary tract infections, and pneumonia. Review of Resident #59's orders dated 04/24/25 revealed the resident was discharged to another long-term care facility. Review of Resident #59's discharge MDS dated [DATE] revealed the resident was discharged and return not anticipated. Review of Resident #59's physician note dated 04/15/25 and signed 04/17/25 revealed [AGE] year-old white male being evaluated for his underlying dementia. Resident had dementia with behavior disturbance. He was at high risk for elopement. The facility had given 30-day notice to residents and family that the security unit will be closing. He was not suitable for the main floor. He was at high risk for elopement. He was in need of security unit to meet his needs and protect him. He was very fidgety, ambulatory, and around other resident rooms. He had to be redirected frequently. Review of SSD #56's note dated 04/15/25 revealed the resident's wife was notified about closing of the memory care unit. The wife thought he would be safer with more supervision. On 04/16/25 the SSD #56 sent a referral to neighboring long term care facility, and they accepted him. The family reported they would like a little more time to find somewhere closer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing progress note dated 04/24/25 revealed Resident #59 was transferred to the facility the SSD sent the original referral to that the family had concerns regarding distance. Review of an undated letter addressed to Resident #59's representative revealed the facility was initiating a 30-day written discharge notice. The letter included that on 04/15/25 that you were notified in person or via telephone on 05/16/25 the Memory Care unit would be closing. All residents residing on the memory care unit were evaluated by the medical director on April 15th (2025) to determine if the resident was appropriate to be moved to the floor or if due to safety concerns they needed different levels of care. The Social Service Designee would continue to work with you to place the resident in an appropriate setting. If you have any concerns, please call me. Please see the attached discharge notice. At the bottom of the letter the State Long Term Care Ombudsman office email was provided along with the Regional, however there was no evidence on how to appeal the discharge. Review of Resident #59's discharge notice undated revealed on 04/15/25 that the resident would be discharged from the facility. If the information in this notice changes prior to the actual transfer or discharge date d, we will update the recipients of this notice. The discharge location and date were left blank. The reason for the discharge was the welfare and needs of the residents cannot be met in the facility. The local Ombudsman number was provided and the email section indicated to see attachment. Resident with mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder was not included in the notice. The notice indicated that a copy of the notice would be sent to the State Health Department and State Long Term Care Ombudsman. There was no evidence that a copy of the discharge order was sent with the discharge notice. The discharge notice was difficult to read due to it having been re-copied and some areas were darkened and not very legible, random lines running through the notice, and wording was blurry. Review of the certified letter receipt undated revealed no evidence the letter was signed or received. The only information on the receipt was an address. There was no evidence that the second certified letter that had the discharge notice was sent and received. Interview on 05/05/25 at 11:29 A.M. and 05/06/25 at 9:59 A.M., with SSD #56 revealed the discharge notice indicated the state health department would be notified of the discharge however he did not send a copy to the state health department. SSD #56 reported original he notified residents representatives via phone or in person on 04/15/25 of the closure of the memory care unit. On 04/16/25 after speaking to the Ombudsman he sent the 30-day notice letter out to all representatives via regular mail and then later that day he sent the same letter out via certified mail. He did not include the attachment (discharge notice) per the letter in the first two letters he sent, so he sent a third certified letter out to include the discharge notice around or on 04/18/25. SSD #56 confirmed the discharge notice did not include all the required information (date and location of discharge or advocate information for residents with mental health disorder). The SSD #56 confirmed he did not send out a revised discharge notice with location and date of discharge to the representative. SSD #56 reported he only received one of the two receipts for the certified letters so he could not confirm the representative received the copy of the discharge notice. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #60's closed medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses including psychosis, dementia, delusional disorder, visual hallucination, panic disorder, essential tremor, anxiety disorder, disorientation, insomnia, depression, and need for assistance with personal care. Review of Resident #60's orders dated 04/18/25 revealed the resident was discharged to another long-term care facility. Review of Resident #60's discharge MDS dated [DATE] revealed the resident was discharged and return not anticipated. Review of Resident #60's social service note dated 04/15/25 revealed the family was informed about the closing of the memory care unit. The family would like the resident to be moved off the unit to another floor if possible. Review of Resident #60's physician note dated 04/15/25 and signed 04/17/25 revealed [AGE] year-old white female being evaluated for her underlying dementia. The facility had elected to close the secured unit in 30 days. Family had been given a note of this. Resident was not suitable for the main floor. She was at high elopement risk. She does try to escape now. She has enough knowledge of how to leave. She also had anxiety hallucinations and delusional disorder. She was on medicines to help control her symptoms. She was calm and pleasant today. Because of her high elopement risk, she will need a secure unit to protect her and this facility cannot meet those needs. We will help facilitate finding a facility that can meet her needs safely. Review of Resident #60's nursing note dated 04/18/25 revealed the resident was discharged to another long-term care facility. Review of an undated letter addressed to Resident #60's representative revealed the facility was initiating a 30-day written discharge notice. The letter included that on 04/15/25 that you were notified in person or via telephone that on 05/16/25 the Memory Care unit would be closing. All residents residing on the memory care unit were evaluated by the medical director on April 15th (2025) to determine if the resident was appropriate to be moved to the floor or if due to safety concerns they needed different levels of care. The Social Service Designee would continue to work with you to place the resident in an appropriate setting. If you had any concerns, please call me. Please see the attached discharge notice. At the bottom of the letter the State Long Term Care Ombudsman office email was provided along with the Regional, however there was no evidence on how to appeal the discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #60's discharge notice undated revealed on 04/15/25 that the resident would be discharged from the facility. If the information in this notice changes prior to the actual transfer or discharge date d, we will update the recipients of this notice. The discharge location and date were left blank. The reason for the discharge was the welfare and needs of the residents cannot be met in the facility. The local Ombudsman number was provided and the email indicated to see attachment. There was no evidence for residents with mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy was included in the notice. The notice indicated that a copy of the notice would be sent to the State Health Department and State Long Term Care Ombudsman. There was no evidence that a copy of the discharge order was sent with the discharge notice. The discharge notice was difficult to read due to it having been re-copied and some areas were darkened and not very legible, random lines running through the notice, and wording was blurry. Review of the certified letter receipt undated revealed the representative received the letter on 04/19/25. There was no evidence that the second certified letter that included the discharge notice was received. Interview on 05/05/25 at 11:29 A.M. and 05/06/25 at 9:59 A.M., with Social Service Designee (SSD) #56 revealed the discharge notice indicated the state health department would be notified of the discharge however he did not send a copy to the state health department. SSD #56 reported original he notified residents representatives via phone or in person on 04/15/25 of the closer of the memory care unit. On 04/16/25 after speaking to the Ombudsman he sent the 30-day notice letter out to all representatives via regular mail and then later that day he sent the same letter out via certified mail. He did not include the attachment (discharge notice) per the letter in the first two letters he sent, so he sent a third certified letter out to include the discharge letter around or on 04/18/25. SSD #56 confirmed the discharge notice did not include all the required information (date and location of discharge or advocate information for residents with mental health disorder). The SSD #56 confirmed he did not send out a revised discharge notice with location and date of discharge to the representative. SSD #56 reported he only received one of the two receipts for the certified letters so he could not confirm the representative received the copy of the discharge notice. 4. Review of Resident #61's closed medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia, wandering disease, dissociative and conversion disorders, amnesia, restlessness and agitation, depression, and need for assistance with personal care. Review of Resident #61's orders dated 04/29/25 revealed the resident may be discharged to a local long care facility per the family request. Review of Resident #61's pending MDS dated [DATE] revealed the resident was discharged and return not anticipated. Review of social service note dated 04/15/25 revealed the social service staff spoke with the family about the closing of the memory care unit. Family thought she would be safer at another facility with a lockdown unit. The family would like a referral sent to local long-term care facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #61's physician note dated 04/15/25 and signed 04/17/25 revealed [AGE] year-old white female being evaluated for her dementia. The facility had given 30-day notice to family and residents as the secured unit will be closing. She was being evaluated for possible main floor. She was at high risk for elopement. Because of this she was at high risk and would be unsafe on the main floor. She needed a secure unit for the safety of her. She did have schizophrenia. She was on Risperdal Consta which did help. She was having intermittent hallucinations and paranoia. She was standing and ambulatory. Because of her high risk of elopement, she will need a secure unit. We will make referrals per family requests. Review of Resident #61's physician note dated 04/24/25 revealed [AGE] year-old white female being evaluated for possibility of being moved to the main floor. After discussions with family, staff administration and family they all would like patient to stay at the facility. She had done better recently. She had not had any serious behaviors. Her medications had stabilized her overall condition. She was to have a wander guard on for the risk of elopement. She was mobile. Will try to maintain mobility. Based on her current stability we will try her out on the main floor to see how she does. Any issues staff will notify me. Review of Resident #61's physician note dated 04/29/25 revealed [AGE] year-old white female being evaluated for discharge visit. Patient was a long-term resident. She had underlying dementia. She was on a secured lockdown unit for her protection. The unit had been closed and she was now out on the main floor. Family had requested transfer to a different facility for the safety of patient and others. We had found the facility that they recommended had accepted the patient. She will be discharged to that facility for continued care and treatment. Patient was sitting up in the chair. She was pleasantly confused. No other complaints mentioned per patient. Review of an undated letter addressed to Resident #61's representative revealed the facility was initiating a 30-day written discharge notice. The letter included that on 04/15/25 that you were notified in person or via telephone that on 05/16/25 the Memory Care unit would be closing. All residents residing on the memory care unit were evaluated by the medical director on April 15th (2025) to determine if the resident was appropriate to be moved to the floor or if due to safety concerns they needed different levels of care. The Social Service Designee would continue to work with you to place the resident in an appropriate setting. If you have any concerns, please call me. Please see the attached discharge notice. At the bottom of the letter the State Long Term Care Ombudsman office email was provided along with the Regional, however there was no evidence on how to appeal the discharge. Review of Resident #61's discharge notice undated revealed on 04/15/25 that the residents would be discharged from the facility. If the information in this notice changes prior to the actual transfer or discharge date d, we will update the recipients of this notice. The discharge location and date were left blank. The reason for the discharge was the welfare and needs of the residents cannot be met in the facility. The local Ombudsman number was provided and the email section indicated to see attachment. There was no evidence for residents with mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder was included in the notice. The notice indicated that a copy of the notice would be sent to the State Health Department and State Long Term Care Ombudsman. There was no evidence that a copy of the discharge order was sent with the discharge notice. The discharge notice was difficult to read due to it having been re-copied and some areas were darkened and not very legible, random lines running through the notice, and wording was blurry. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the certified letter receipt undated revealed the representative received the letter on 04/19/25. Interview on 05/05/25 at 12:14 P.M., with Resident #61's representative revealed the facility had sent a referral to a long-term care facility about an hour away and the resident was accepted, however the family declined. The resident was discharged to a local long term care facility down the road. The representative confirmed she only received a one-page letter via regular mail and a one-page letter via certified mail. The representative confirmed she did not receive a second certified letter with the discharge notice or how to appeal the discharge. Interview on 05/05/25 at 11:29 A.M. and 05/06/25 at 9:59 A.M., with Social Service Designee (SSD) #56 revealed the discharge notice indicated the state health department would be notified of the discharge, however he did not send a copy to the state health department. SSD #56 reported originally he notified resident representatives via phone or in person on 04/15/25 of the closure of the memory care unit. On 04/16/25 after speaking to the Ombudsman he sent the 30-day notice letter out to all representatives via regular mail and then later that day he sent the same letter out via certified mail. He did not include the attachment (discharge notice) per the letter in the first two letters he sent, so he sent a third certified letter out to include the discharge letter around or on 04/18/25. SSD #56 confirmed the discharge notice did not include all the required information (date and location of discharge or advocate information for residents with a mental health disorder). The SSD #56 confirmed he did not send out a revised discharge notice with location and date of discharge to the representative. Interview on 05/15/25 at 8:43 A.M., via email with the Director of Nursing (DON) revealed Resident #61 was transferred out of the secure unit on 04/24/25 to room [ROOM NUMBER] until she was discharged to another facility on 05/02/25. 5. Review of Resident #62's closed medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, unspecified psychosis, insomnia, disorientation, and needs for assistance with personal care. Review of Resident #62's orders dated 04/18/25 revealed the resident may be discharged to a local long term care facility per the family request. Review of Resident #62's MDS dated [DATE] revealed the resident was discharged and return not anticipated. Review of Resident 62's social service note dated 04/15/25 revealed the resident representative was notified the memory care unit was closing down. The representative would like her to stay if possible, but she was also fine with her going to a new facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #62's physician note dated 04/15/25 and signed 04/17/25 revealed [AGE] year-old white female being evaluated for her underlying dementia. The secured unit will be closed in 30 days. All the residents had been given 30-day notice. Family was present. They understand that we cannot meet her needs here without a secure unit and will need another facility. They have asked us to try to find a facility that is closer to home and not give the information to staff. Also, the resident had severe anxiety, was tearful. She did get very anxious at times. She was anxious this evening. Patient was on Buspar and once daily Ativan for anxiety. Resident was an elopement risk with her dementia. She did require a secure environment for her safety issues. Review of Resident #62's nursing note dated 04/18/25 revealed the resident was discharged to a long-term care facility (40 minutes away). Review of an undated letter addressed to Resident #62's representative revealed the facility was initiating a 30-day written discharge notice. The letter included that on 04/15/25 that you were notified in person or via telephone that on 05/16/25 the Memory Care unit would be closing. All residents residing on the memory care unit were evaluated by the medical director on April 15th (2025) to determine if the resident was appropriate to be moved to the floor or if due to safety concerns they needed different levels of care. The Social Service Designee would continue to work with you to place the resident in an appropriate setting. If you have any concerns, please call me. Please see the attached discharge notice. At the bottom of the letter the State Long Term Care Ombudsman office email was provided along with the Regional, however there was no evidence on how to appeal the discharge. Review of Resident #62's discharge notice undated revealed on 04/15/25 that the resident would be discharged from the facility. If the information in this notice changes prior to the actual transfer or discharge date d, we will update the recipients of this notice. The discharge location and date were left blank. The reason for the discharge was the welfare and needs of the residents cannot be met in the facility. The local Ombudsman number was provided and the email section indicated to see attachment. There was no evidence for residents with mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder was included in the notice. The notice indicated that a copy of the notice would be sent to the State Health Department and State Long Term Care Ombudsman. There was no evidence that a copy of the discharge order was sent with the discharge notice. The discharge notice was difficult to read due to it having been re-copied and some areas were darkened and not very legible, random lines running through the notice, and wording was blurry. Review of the certified letter receipt undated revealed the representative received the letter however there was no date when it was received. There was no evidence that the representative received the second certified letter. Interview on 05/05/25 at 12:29 P.M., with Resident #62's representative revealed the discharge process was very fast paced, however it ended up being a good move since the other residents from the memory care unit were transferred to the same facility. The facility was a little further (1:45 minutes away) from her and she can't visit as frequently as she would like, but she had another resident family check on her resident frequently that lives close. The representative reported she was not provided with a discharge notice on how to appeal the discharge. She had only received a one-page letter twice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/05/25 at 11:29 A.M. and 05/06/25 at 9:59 A.M., with Social Service Designee (SSD) #56 revealed the discharge notice indicated the state health department would be notified of the discharge however he did not send a copy to the state health department. SSD #56 reported original he notified residents representatives via phone or in person on 04/15/25 of the closer of the memory care unit. On 04/16/25 after speaking to the Ombudsman he sent the 30-day notice letter out to all representatives via regular mail and then later that day he sent the same letter out via certified mail. He did not include the attachment (discharge notice) per the letter in the first two letters he sent, so he sent a third certified letter out to include the discharge letter around or on 04/18/25. SSD #56 confirmed the discharge notice did not include all the required information (date and location of discharge or advocate information for residents with a mental health disorder). The SSD #56 confirmed he did not send out a revised discharge notice with location and date of discharge to the representative. SSD #56 confirmed there was no documented evidence that the representative received the discharge notice due to he only received one certified receipt back. Interview on 05/05/25 at 12:53 P.M., with the Administrator confirmed Resident #58, #59, #60, #61, and #62's discharge notices were not completed to include the required information such as date and location of discharge. The Administrator confirmed the state health department was not notified of the five discharges as well. Interview on 05/05/25 at 11:43 via email with the Local Ombudsman revealed she had concerns with improper discharges when the facility closed the memory care unit. The facility had reported they had provided 30-day notices to the residents/representatives. When the Ombudsman asked the facility for copies of the discharge notices as they were not sent to her the SSD #56 told her the Administrator told him they did not have to provide those to her, and they were doing everything right and the Ombudsman would get a notice with the monthly transfer and discharges notices. The Ombudsman explained to the SSD the discharge process included sending the ombudsman the notice he then went on to say they did not do a notice only phone calls. The Ombudsman explained the resident had a right to a 30-day notice. The SSD eventually called her back and sent a notice. The notice was not appropriate. He did not include information about an appeal or discharge location, etc. it just said you [TRUNCATED]