STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375572	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	102 East Line Avenue Sapulpa, OK 74066

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 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. 30267 Based on record review and interview, the facility failed to: a. give 30 days notice in writing of the resident's planned transfer/discharge to the resident/representative; b. send a copy of the notice of transfer/discharge to the ombudsman's office; c. provide the resident with a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which received such requests; d. provide information on how to obtain an appeal form; e. assist the resident in completing the form and submitting the appeal hearing request; f. provide the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities; and g. the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder for one (#1) of three sampled residents whose clinical records were reviewed for transfer/discharge requirements. The facility admission/discharge list documented four residents who were transferred to the hospital since 10/01/24. Findings: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Beacon Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 102 East Line Avenue Sapulpa, OK 74066	

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, titled Transfer or Discharge, Facility-Initiated and dated October 2022, read in parts, Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility .When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility .Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care ombudsman .Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. If discharge is initiated by the facility after an emergency tranfers to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). If the facility does not permit a resident's return to the facility based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice of the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility. Resident #1 had diagnoses which included fetal alcohol syndrome, schizophrenia, intellectual disabilities, and bipolar disorder. A nurse's progress note, dated 12/05/24, documented the resident was admitted to the facility from another nursing home, was pleasant, and was alert and oriented to person, place, time, and situation. The note documented the resident requested and received a tour of the facility. A nurses' progress note, dated 12/11/24, read in part, Call from [local hospital #1] on resident for information on why [they] went to the hospital. Resident refused treatment or to sign consent [for facility] to treat. Resident wanted to leave facility and no longer be here. Resident refusing care at this facility and has been aggressive both physically and sexually to staff. Resident assaulted staff by hitting [them] with a wooden sign. Resident is a danger to staff and other residents. Resident refusing care causes resident to be a danger to [themselves]. Nurse will relay message to the doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Beacon Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 102 East Line Avenue Sapulpa, OK 74066	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note, dated 12/12/24, read in part, [Local ambulance service] brought [Resident #1] back to facility without report being called from [local hospital #1]. This facility has no right to treat [Resident #1] or make [Resident #1] stay as [Resident #1] expressed before leaving facility, Resident is a danger to staff and [themselves] as [themselves] has physically assaulted staff and refusing to consent to be treated poses a threat to [Resident #1's] health. Resident stated [they] wanted to go to [local hospital #2]. [Local ambulance service] called back and spoke with ADON and this nurse. Social worker at [local hospital #2] was notified by this nurse of situation with resident. Social worker stated [they] will call back after discussing situation with doctor and advised nurse this person usually goes to [satellite location for local hospital #2], not Tulsa. The nurse's note, dated 12/12/24, read in parts, Call back from Social Worker .[Social worker] wants to know if we will accept [Resident #1] back if [they] will sign consents and paperwork to treat at this facility. Informed social worker of inappropriate behavior, assaulting staff both physically and sexually, and assaulted [local ambulance service] staff when transferring, which is unlawful. Social worker will reach out to [their] DHS contact and would like to know if it is possible to send [Resident #1] back or if other arrangements need to be made. Informed SW I would send message to DON. Message sent to DON with phone number of SW. On 01/14/24 at 3:11 p.m., the ambulance service director was asked if the ambulance service transported Resident #1 on 12/11/24. The director stated the ambulance service transported the resident from hospital #1 back to the facility. The director stated it was a bitterly cold night and the resident was lightly clothed and strapped to a gurney. The director stated the facility staff refused to open the door and allow the resident and staff to enter the facility and discuss the situation. The director stated neither they nor the resident were informed of why the facility would not accept the resident back nor were they provided any paperwork from the facility. The director stated they had to transport the resident to another local hospital. On 01/24/25 at 3:15 p.m., LPN #1 stated when a resident was transferred/discharged to the hospital, the nurse was responsible for filling out the transfer packet. The LPN stated they read the forms to the resident before they were transferred, but the resident did not receive a copy of the forms and nothing was sent with the resident or ambulance personnel. The LPN stated the first form was a notice of transfer or discharge and documented where the resident was to transfer/discharge, the reason for the transfer or discharge, and the option for the resident to have their bed held. The LPN stated the second form was a check list of responsibilities for the nurse to complete prior to the resident's transfer/discharge. The LPN stated the third form was a certificate of medical necessity for emergency ambulance transport. The LPN stated the fourth, fifth, and sixth forms in the packet were not used. A review of the fourth form revealed it documented the resident had a right to appeal the decision to tranfers and provided the resident with an old address and contact information for the State Department of Health Long Term Care Division and the ombudsman's contact information. The fifth form was another facility check off list documenting the nurses' responsibilities with each resident transfer/discharge. The sixth form was another certificate of medical necessity to transport via ambulance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Beacon Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 102 East Line Avenue Sapulpa, OK 74066	

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/25 at 3:30 p.m., the social service director stated Resident #1 refused to sign the facility's consent to treat form and wished to go to a local company which worked directly with residents with intellectual disabilities. The social service director stated they had not contacted DHS Department of Developmental Disabilities nor contacted the local company to determine if a transfer was possible. The social service director stated they were not involved in the resident's transfer to the hospital and did not provide the resident with the discharge or bed-hold policy. On 01/24/25 at 3:45 p.m., the administrator stated Resident #1 did not want to live in the facility and instead wished to move to a local company that provided services to individuals with intellectual disabilities. The administrator stated the resident refused care and would not sign the facility's consent to treat form. The administrator denied contacting DHS and making a referral for services for a resident with intellectual disabilities nor contacting the local company which provided such services. The administrator was asked to provide documentation the facility assisted the resident with transferring to the local company for individuals with intellectual disabilities, documentation of the interventions attempted or used to encourage the resident's cooperation with care, what referrals were made on the resident's behalf, and who the facility contacted to help encourage the resident to cooperate with care (i.e. physician, psychiatric consult, ombudsman). The administrator reviewed the clinical record and stated there was no documentation to support any referrals were made or anyone was contacted/interventions changed to encourage the resident to cooperate with care. The administrator was asked to provide documentation the facility: a. provided the resident with a 30 days notice in writing of the resident's planned transfer/discharge to the resident/representative; b. sent a copy of the notice of transfer/discharge to the Ombudsman's office; c. provided the resident with a statement of the resident's appeal rights; d. provided information on how to obtain an appeal form; e. assisted the resident in completing the form and submitting the appeal hearing request; f. provided the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities; and g. provided the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder. On 01/24/25 at 4:45 p.m., the administrator stated there was no such documentation in the resident's clinical record. The administrator stated they needed to in-service staff on the facility transfer/discharge/bed-hold policies and revise their transfer/discharge packets to ensure policies were followed and residents received the appropriate paperwork.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 30267 Based on record review and interview, the facility failed to provide the bed-hold policy to one (#1) of three sampled residents who were transferred to the hospital. The facility admission/discharge list documented four residents who were transferred to the hospital since 10/01/24. Findings: The facility policy, titled Bed-Holds and Returns and dated October 2022, read in parts, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice . notice 1: well in advance of any transfer (e.g. in the admission packet); and notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). Resident #1 had diagnoses which included fetal alcohol syndrome, schizophrenia, intellectual disabilities, and bipolar disorder. A nurse's progress note, dated 12/05/24, documented the resident was admitted to the facility from another nursing home, was pleasant, and was alert and oriented to person, place, time, and situation. The note documented the resident requested and received a tour of the facility. A nurses' progress note, dated 12/11/24, read in part, Call from [local hospital #1] on resident for information on why [they] went to the hospital. Resident refused treatment or to sign consent to treat. Resident wanted to leave facility and no longer be here. Resident refusing care at this facility and has been aggressive both physically and sexually to staff. Resident assaulted staff by hitting [them] with a wooden sign. Resident is a danger to staff and other residents. Resident refusing care causes resident to be a danger to [themselves]. Nurse will relay message to the doctor. A nurse's note, dated 12/12/24, read in part, [Local ambulance service] brought [Resident #1] back to facility without report being called from [local hospital #1]. This facility has no right to treat [Resident #1] or make [Resident #1] stay as [Resident #1] expressed before leaving facility, Resident is a danger to staff and [themselves] as [themselves] has physically assaulted staff and refusing to consent to be treated poses a threat to [Resident #1's] health. Resident stated [they] wanted to go to [local hospital #2]. [Local ambulance service] called back and spoke with ADON and this nurse. Social worker at [local hospital #2] was notified by this nurse of situation with resident. Social worker stated [they] will call back after discussing situation with doctor and advised nurse this person usually goes to [satellite location for local hospital #2], not Tulsa. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 12/12/24, read in parts, Call back from Social Worker .[Social worker] wants to know if we will accept [Resident #1] back if [they] will sign consents and paperwork to treat at this facility. Informed social worker of inappropriate behavior, assaulting staff both physically and sexually, and assaulted [local ambulance service] staff when transferring, which is unlawful. Social worker will reach out to [their] DHS contact and would like to know if it is possible to send [Resident #1] back or if other arrangements need to be made. Informed SW I would send message to DON. Message sent to DON with phone number of SW. On 01/14/24 at 3:11 p.m., the ambulance service director was asked if the ambulance service transported Resident #1 on 12/11/24. The director stated the ambulance service transported the resident from hospital #1 back to the facility. The director stated it was a bitterly cold night and the resident was lightly clothed and strapped to a gurney. The director stated the facility staff refused to open the door and allow the resident and staff to enter the facility and discuss the situation. The director stated neither they nor the resident were informed of why the facility would not accept the resident back nor were they provided any paperwork from the facility. The director stated they had to transport the resident to another local hospital. On 01/24/25 at 3:15 p.m., LPN #1 stated when a resident was transferred/discharged to the hospital, the nurse was responsible for filling out the transfer packet. The LPN stated they read the forms to the resident before they were transferred, but the resident did not receive a copy of the forms and nothing was sent with the resident or ambulance personnel. The LPN stated the first form was a notice of transfer or discharge and documented where the resident was to transfer/discharge, the reason for the transfer or discharge, and the option for the resident to have their bed held. The LPN stated the second form was a check list for the nurse to complete prior to the resident's transfer/discharge. The LPN stated the third form was a certificate of medical necessity for emergency ambulance transport. The LPN stated the fourth, fifth, and sixth forms in the packet were not used. A review of the fourth form revealed it documented the resident had a right to appeal the decision to tranfers and provided the resident with an old address and contact information for the State Department of Health Long Term Care Division and the ombudsman's contact information. The fifth form was another facility check off list documenting the staffs responsibilities with each resident transfer/discharge. The sixth form was another certificate of medical necessity to transport via ambulance. On 01/24/25 at 3:30 p.m., the social service director stated Resident #1 refused to sign the facility's consent to treat form and wished to go to a local company which worked directly with residents with intellectual disabilities. The social service director stated they had not reach out to the local company to determine if a transfer was possible. The social service director stated they were not involved in the resident's transfer to the hospital and did not provide the resident with the discharge or bed-hold policy. The social service director stated they were new to the position and did not know they needed to chart in the clinical record. On 01/24/25 at 3:45 p.m., the administrator stated Resident #1 did not want to live here and instead wished to move in with a local company that provided services to individuals with intellectual disabilities. The administrator stated the resident refused care and would not sign the facility's consent to treat form. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator was asked to provide documentation the facility assisted the resident with transferring to the local company for individuals with intellectual disabilities, documentation of the interventions attempted or used to encourage the resident's cooperation with care, what referrals were made on the resident's behalf, and who the facility contacted to help encourage the resident to cooperate with care (i.e. physician, psychiatric consult, ombudsman). The administrator reviewed the clinical record and stated there was no documentation to support any referrals were made or anyone was contacted/interventions changed to encourage the resident to cooperate with care. The administrator was asked to provide copies of the discharge and bed-hold policies provided to Resident #1 and documentation the resident's representative, ombudsman, and the State LTC office were notified of the discharge. On 01/24/25 at 4:45 p.m., the administrator stated there was no documentation the resident received the proper policies nor of the ombudsman or State LTC office being notified of the discharge. The administrator stated they needed to in-service staff on the facility transfer/discharge/bed-hold policies and revise their transfer/discharge packets to ensure residents received the appropriate paperwork.

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F 0626

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.

30267

Based on record review and interview, the facility failed to allow one (#1) of three sampled residents who were transferred to the hospital to return to the facility.

The facility admission/discharge list documented four residents who were transferred to the hospital since 10/01/24.

Findings:

The facility policy, titled Transfer or Discharge, Facility-Initiated and dated October 2022, read in parts, Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility .When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility .If discharge is initiated by the facility after an emergency tranfers to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). If the facility does not permit a resident's return to the facility based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice of the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

Resident #1 had diagnoses which included fetal alcohol syndrome, schizophrenia, intellectual disabilities, and bipolar disorder.

A nurse's progress note, dated 12/05/24, documented the resident was admitted to the facility from another nursing home, was pleasant, and was alert and oriented to person, place, time, and situation. The note documented the resident requested and received a tour of the facility.

A nurses' progress note, dated 12/11/24, read in part, Call from [local hospital #1] on resident for information on why [they] went to the hospital. Resident refused treatment or to sign consent to treat. Resident wanted to leave facility and no longer be here. Resident refusing care at this facility and has been aggressive both physically and sexually to staff. Resident assaulted staff by hitting [them] with a wooden sign. Resident is a danger to staff and other residents. Resident refusing care causes resident to be a danger to [themselves]. Nurse will relay message to the doctor.

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note, dated 12/12/24, read in part, [Local ambulance service] brought [Resident #1] back to facility without report being called from [local hospital 1]. This facility has no right to treat [Resident #1] or make [Resident #1] stay as [Resident #1] expressed before leaving facility, Resident is a danger to staff and [themselves] as [themselves] has physically assaulted staff and refusing to consent to be treated poses a threat to [Resident #1's] health. Resident stated [they] wanted to go to [local hospital #2]. [Local ambulance service] called back and spoke with ADON and this nurse. Social worker at [local hospital #2] was notified by this nurse of situation with resident. Social worker stated [they] will call back after discussing situation with doctor and advised nurse this person usually goes to [satellite location for local hospital #2], not Tulsa. The nurse's note, dated 12/12/24, read in parts, Call back from Social Worker .[Social worker] wants to know if we will accept [Resident #1] back if [they] will sign consents and paperwork to treat at this facility. Informed social worker of inappropriate behavior, assaulting staff both physically and sexually, and assaulted [local ambulance service] staff when transferring, which is unlawful. Social worker will reach out to [their] DHS contact and would like to know if it is possible to send [Resident #1] back or if other arrangements need to be made. Informed SW I would send message to DON. Message sent to DON with phone number of SW. On 01/24/25 at 3:15 p.m., LPN #1 stated when a resident was transferred/discharged to the hospital, the nurse was responsible for filling out the transfer packet. The LPN stated they read the forms to the resident before they were transferred, but the resident did not receive a copy of the forms and nothing was sent with the resident or ambulance personnel. The LPN stated the first form was a notice of transfer or discharge and documented where the resident was to transfer/discharge, the reason for the transfer or discharge, and the option for the resident to have their bed held. The LPN stated the second form was a check list for the nurse to complete prior to the resident's transfer/discharge. The LPN stated the third form was a certificate of medical necessity for emergency ambulance transport. The LPN stated the fourth, fifth, and sixth forms in the packet were not used. A review of the fourth form revealed it documented the resident's right to appeal the decision to tranfers and provided the resident with an old address and contact information for the State Department of Health Long Term Care Division and the ombudsman's contact information. The fifth form was another facility check off list documenting the staffs responsibilities with each resident transfer/discharge. The sixth form was another certificate of medical necessity to transport via ambulance. On 01/24/25 at 3:30 p.m., the social service director stated Resident #1 refused to sign the facility's consent to treat form and wished to go to a local company which worked directly with residents with intellectual disabilities. The social service director stated they had not reach out to the local company to determine if a transfer was possible nor contacted DHS. The social service director stated they were not involved in the resident's transfer to the hospital and did not provide the resident with the discharge or bed-hold policy. The social service director stated they were new to the position and did not know they were to chart in the resident's clinical records until after the resident had discharged . (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/25 at 3:45 p.m., the administrator stated Resident #1 did not want to live in the facility and instead wished to move to a local company that provided services to individuals with intellectual disabilities. The administrator stated the resident refused care and would not sign the facility's consent to treat form. The administrator denied contacting DHS, making a referral for services for a resident with intellectual disabilities, nor contacting the local company which provided such services. The administrator was asked to provide documentation the facility followed their policies and provided the resident with the information to appeal his discharge, assisted the resident in obtaining the forms, and provided the resident with the appropriate contact information to appeal the decision with OSDH. The administrator was asked to provide documentation the resident/resident's representative, ombudsman, and the State LTC office were notified of the discharge and when the individual entities were notified. On 01/24/25 at 4:45 p.m., the administrator stated there was no such documentation in the resident's clinical record. The administrator stated they needed to in-service staff on the facility transfer/discharge/bed-hold policies and revise their transfer/discharge packets to ensure policies were followed and residents received the appropriate paperwork.