STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395203	A. Building B. Wing	03/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Prospect	815 Chester Pike Prospect Park, PA 19076

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 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record reviews, interviews with staff, review of hospital records and review of policy and procedure, it was determined that the facility failed to properly discharge Resident CI1 who was assessed by the facility as requiring guidance for safety awareness and problems with short term memory for one of three closed records reviewed. (Resident CI1) This failure resulted in an Immediate Jeopardy situation for Resident CI1 whose safety device was removed by facility staff allowing the resident to exit the building, discharging the resident against medical advice to an unknown location and without returning resident's identification documents. Further the facility failed to notify the required State authorities and resident's family of the resident's discharge. (Resident CI1) Findings include: A review of the facility policy titled Discharging a Resident without a Physician's Approval dated August 2022, revealed that the resident's attending physician must be notified of a resident or resident's representative's desire for immediate discharge. This policy also indicated that a signed and dated order for approval of this discharge must be recorded in the clinical record. Continued review of the policy revealed that a resident must sign and date a release form and that two staff members must witness this form by signing and dating the form. A review of the policy titled Discharge Summary and Plan dated August 2022, revealed that each resident was to have an assessment and care plan for an expected discharge. The policy also indicated that a discharge summary and post-discharge plan was to be developed for each resident, to assist the resident to adjust to his/her new living arrangement. The policy indicated that the post discharge plan would be developed by the care plan team, the resident and his or her family that was to include: where the individual plans to reside, arrangements that have been made for follow-up care, a description of the resident's stated discharge goals, the degree of caregiver support and how the resident can prevent a readmission and contact with local community agencies. (continued on next page)

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

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the policy titled Resident Transfer and Discharge Policy and Procedure dated 2023, revealed that the purpose of this policy was to ensure that all residents being transferred or discharged were subject to a standardized process so that each discharge or transfer was according to regulatory process, ethics and quality of care. This policy also indicated that before the facility transfers or discharges a resident, the facility must notify the resident and the resident's representative of the reason for transfer or discharge in writing and a manner that the resident understands. Send a copy of the notice to a representative of the Office of State Long-Term Care Ombudsman. Record the reason for the transfer or discharge in the resident's clinical record. Inform the resident or the resident representative as to where the resident was being transferred was a Medicare or Medical Assistance provider. The policy said that the written notice shall include: The reason for the transfer or discharge, the effective date for transfer or discharge, the specific location to which the resident was to transfer or discharge (address of the residence), A statement of the resident's appeal rights (emailing or mailing address), the name address and telephone number of the State Long Term Care Ombudsman, for residents with mental disorder, intellectual an developmental disabilities or related disabilities the mailing address of the Protection and Advocacy groups. The policy indicated that the timing of the notice was 30 days before transfer or discharge. According to this policy the facility was responsible to provide orientation to the resident before transferring or discharging them. The facility was responsible for documenting sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. The orientation must be provided in a form and manner that the resident could understand. Review of Resident Cl1's clinical record revealed that the resident was admitted on [DATE], with a history of delirium and confusion due to a diagnosis of hepatic encephalopathy (a loss of brain function as a result of failure in the removal of toxins from the blood due to liver damage). Review of nursing progress note dated February 9, 2024, indicated that Resident Cl1 was showing symptoms of unsteady gait and voiding on the floor; the resident said the reason for the voiding on the floor was because he had a hernia. The nursing note also stated that Resident Cl1 was frustrated because he could not get the proper words to speak. The certified nurse practitioner was contacted and gave orders to send the resident out to the hospital for treatment of hepatic encephalopathy. Continue review of nursing documentation revealed that the resident was readmitted to the facility on [DATE]. Review of Resident Cl1's admission Minimum Data Set (MDS- an assessment of care needs) dated February 15, 2024, indicated that the resident had moderately impaired cognition. The assessment also indicated that Resident Cl1 was exhibiting behaviors of inattention and disorganized thinking. The resident was noted saying that it was very important for family or close friend to be involved in discussion about his care. The assessment indicated impairment or limitations to funtional abilities for Resident Cl 1 of bilateral lower extremity impairments, with a need for a mobility device. Resident Cl1 required supervision, touching and cueing from staff, for safe transfers and to safely position from sitting to standing. The resident was occasionally incontinent of urine and frequently incontinent of bowel. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident C11's care plan initiated February 14, 2024, revealed that the resident was identified with a history of delirium or an acute confusion episodes related to metabolic/hepatic encephalopathy. The interventions included to monitor the resident's safety every shift. Continued review of the resident's care plan revealed that the resident was care planned for symptoms that increase safety risk which included confusion, delirium, dizziness and for the potential for fall related to a decline in functional statues. On February 28, 2024, a care plan was initiated for the resident having the potential for elopement related to exit seeking behavior. The interventions included to check resident's whereabouts frequently, make receptionist and other staff aware of elopement risk and notify social services for persistent attempts to leave building and not responding to redirection. On February 29, 2024, the intervention of wanderguard (alarming device that locks doors specific doors to prevent the resident for leaving the building) to right ankle was initiated. Review of physician's notes dated February 28, 2024, indicated that Resident CI1 had increased anxiety and pacing behaviors. The resident had several elopement attempts from the facility, requiring a wanderguard. The resident confirmed the increased anxiety and wanting to punch somebody. The resident was reporting to the physician that he used alcohol three to four times a week. The physician indicated that this resident was oriented to name only with an anxious mood and behavior agitated when approached. The physician wanted psychiatry to exam and treat this resident. Interview with the Director of Nursing, Employee E2, on March 7, 2024, at 10:30 a.m. confirmed that the facility had not consulted the psychiatry or psychologist to assess, evaluate and treat Resident CI1. Review of the Speech/Language/Swallowing Pathologist's notes dated March 1, 2024, revealed that the therapist was evaluating Resident CI1 and determined that his cognition level was moderately impaired. The note indicated that the therapist had to provide moderate cues with memory compensatory strategies for the resident to recall dates, times. The therapist indicated that Resident CI1 was extremely erratic with moments of aggression during therapy. Interview with Employee E21, Speech/Language/Swallowing Pathologist on March 7, 2024, at 1:00 p.m., confirmed that Resident CI1 was moderately cognitively impaired, had short term memory loss, was forgetful and frustrated with his memory impairment. The therapist explained that this resident needed cues from staff for orientation and safety awareness. Review of Physical Therapist's note dated February 28, 2024, revealed that Resident CI1 was using hand held assistance and supervision of one staff member for ambulation. Interview with the Physical Therapist, Employee E22, on March 7, 2024, at 1:30 p.m., revealed that Resident CI1 was trialing a hand held assistive device (wheeled walker) to ambulate safely short distances of ten feet on March 1, 2024. Review of nursing note dated March 4, 2024, revealed that Resident CI1 left the facility, because he was requesting to leave the facility. The nursing note indicated that the resident was ambulating as he left the facility. Interview with the Director of Nursing, Employee E2 on March 7, 2024, at 2:00 p.m., revealed that the wanderguard was removed from Resident CI1's right ankle on March 4, 2024; so that Resident CI1 could ambulate out the front entrance of the facility, without triggering the alarm system. (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 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Nursing Home Administrator, Employee E1, on March 7, 2024, at 2:30 p.m., confirmed that Resident CI1 had ambulated out the entrance of the facility. The Nursing Home Administrator, Employee E1 also confirmed that the facility had no idea of Resident CI1's whereabouts. Interview with the Nursing Home Administrator, Employee E1, Director of Nursing, Employee E2 and Social Worker, Employee E6 at 9:00 a.m., on March 8, 2024, revealed that Resident CI1 was asked to sign and date a release for discharge against medical advice form on March 4, 2024. Review of this form revealed that a signature; however, no date was completed. Further review of this form revealed that there was only one witness signature by staff on this form. According to the facility's established policy two witness signatures were required. Interview with the Director of Nursing, Employee E2 and the Social Worker, Employee E6, on March 8, 2024, at 9:30 a.m., revealed that prior to discharge of Resident CI1 on March 4, 2024, there was no contact with the resident's physician's about anticipated discharge planning. Employees E2 and E6 also confirmed that before discharge of Resident CI1, who was cognitively impaired, there was no contact with the resident's family and responsible party. Employees E2 and E6 confirmed during this interview that the office of the State Long Term Care Ombudsman was not notified before resident CI1's discharge on March 4, 2024. Employees E2 and E6 also confirmed during the interview that the agency responsible for the protection and advocacy of mental disorders was not notified about the discharge of Resident CI1 from the facility on March 4, 2024. Interview with the Licensed nurse, Employee E23, on March 8, 2024 at 10:00 a.m., revealed that this nurse was not aware on March 4, 2024 that Resident CI1 left the facility alone and without an address or specific location to which he was discharged . The licensed nurse, Employee E23 stated that the resident's belongings (identification cards license and credit cards) were in the nursing medication cart. Licensed nurse, Employee E23 who was familiar with Resident CI1 was concerned for his welfare being discharge with no walker; since he was at risk for falls, no medications, no safe place to live with food and water, no money and no friend or family contact or means of contacting friends, family or public help. Interview with nursing assistant, Employee E17, on March 8, 2024, at 10:30 a.m., revealed that Resident CI1 was using the telephone at the nurse's station on March 2 and March 3, 2024, to contact a friend. The resident was telling the nursing assistant, Employee E17 on March 2 and 3, 2024, that he wanted to leave to get some money from his friend. Employee E17 reported that Resident CI1 was confused and not steady on his feet. The resident did require her help with grooming (shaving) because Resident CI1 lacked the coordination and dexterity to complete the task safely. Interview with nursing assistant, Employee 18, on March 8, 2024, at 10:45 a.m., revealed that Resident CI1 was not alert and oriented. During conversations with Resident CI1 the first three minutes of the conversation was lucid and the rest of the conversation was incoherent. Interview with the Licensed nurse, Employee E19 on March 8, 2024, at 11:00 a.m., revealed that Resident CI1 presented to this nurse as exit seeking. He would be in the lounge starring out the window waiting for someone to pick him up or visit. The resident would say a person outside the facility owed him money. The nurse said that Resident CI1 was disoriented and was not able to tell her who the person was or provide contact information for this person Resident CI1 was trying to remember. Licensed nurse, Employee E19 reported that this resident was unkept unless staff would encourage him to dress, groom and bath regularly. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Nursing Home Administrator, on March 7, 2024 at 3:10 p.m., revealed that Resident CI1 was located at the emergency room of a local hospital on March 4, 2024. A review of the hospital record dated March 4, 2024, revealed that Resident CI1 arrived at the hospital emergency room by ambulance at 11:30 p.m., with a wet incontinent brief and stating he had no where to go. The hospital staff documented that they gave the resident clean pants, a brief, blankets, something to eat and allowed Resident CI1 to use the phone. The hospital record indicated that Resident CI1 needed a bed to sleep. The hospital staff documented that weather outside was raining with low air temperatures. The hospital staff conducted blood testing for Resident CI1 and indicated that blood ammonia levels were elevated at 145UG/DL (Normal levels in the blood were 0 to 60 UG/DL). This deficiency was identified as Immediate Jeopardy for failure to provide and ensure the proper and orderly discharge of Resident CI1 who was assessed with short term memory problems, requiring guidance for safety awareness and orientation and had a history of exit seeking behavior. An immediate jeopardy template (a document which included information necessary to establish each of the key components of the immediate jeopardy) was provided to the Nursing Home Administrator on March 8, 2024, at 11:46 a.m. The facility's action plan included the following: The facility will ensure that all residents with short term memory problems and/or a history of exit seeking behavior have a proper and orderly discharge. The facility will ensure a safe and proper discharge for all residents requiring guidance for safety awareness, orientation and problems with short term memory and that residents who are no longer appropriate for wander guard intervention are reviewed by the IDT and physician orders are received prior to removing the wander guard. 1. The identified resident was no longer residing in the facility. Facility nursing home administrator immediately notified adult protective services to ensure that they would follow up with the resident, who now resides in the community on March 8, 2024. 2. The facility nursing home administrator immediately began providing education to the clinical and social services staff regarding the facility policy for resident discharge and residents leaving against medical advice for residents requiring guidance for safety awareness, orientation and problems with short term memory loss based on the standard brief interview for mental status, clinical assessments and care plans. 3. The facility immediately began providing education to licensed nursing and social service staff on policies related to discharge and resident leaving against medical advice. The facility will complete approximately 80% education prior to the end of the day March 8, 2024. All licensed nursing and social services staff will receive this education prior to starting their next scheduled shift until 100% of all staff are trained and educated. 4. The facility nursing home administrator provided education to administrative nurses and social services staff on abuse and neglect and notification of adult protective services for residents who discharge to the community against medical advice or with concerns for post discharge safety. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The facility nursing home administrator provided education to administrative nurses and social services staff on escalation of issues when they are unable to reach the resident's family or responsible party and to notify the residents physician when multiple attempts to reach the family or responsible party are unsuccessful. 6. The facility nursing home administrator provided education to administrative nurses and social services staff on tracking and returning resident identification documents at discharge for against medical advice or planned discharges. 7. The regional clinical consultant immediately began providing education to licensed nursing staff, social service staff and nursing home administrator on proper removal of wander guard devices. 8. The facility will identify all residents in the population with the potential to be affected by this deficient practice by auditing of all discharges, against medical advice and otherwise within the past 30 days to ensure proper notification of the responsible party, emergency contact, physician and state authorities was completed. 9. The facility will audit all discharges from the facility to ensure a proper and orderly discharge and to ensure that all proper notifications were made as follows: 100% of all resident discharges will be reviewed for the following 90 days. Any trends identified in these audits will be reported to the facility QAPI (Quality Assurance Program Improvement) committee and this plan of correction will be modified to address those trends as needed. 10. The facility Ad [NAME] QAPI committee will review facility policies related to resident discharge and discharge against medical advice to ensure they adhere to state and federal requirements for a safe and orderly discharge by the end of the day March 8, 2024. On March 8, 2024, at 5:45 p.m. the facility's immediate action plan was accepted. Interviews with licensed nursing staff, social services staff and administrative staff confirmed that they were knowledgeable of all facility's safe and orderly discharge policies and procedures that included discharges against medical advice. Interviews with licensed nursing staff, social services staff and administrative staff confirmed that they were knowledgeable about obtaining orders from the physician before the removal a wander guard device, identification of a resident with cognitive impairments through brief interview for mental status, clinical assessment and care plan, notifications of the physician, responsible party and state authority before discharge of a resident. The 30- day audit was reviewed to reveal that proper notifications to responsible party, emergency contacts, physicians and state authorities. On March 9, at 5:05 p.m., the Immediate Jeopardy was lifted. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that one of XXX residents reviewed received psychiatric consultations as ordered by the physcian.(Resident CI1) Findings include: Review of Resident CI1's clinical record revealed that the resident was admitted admitted on [DATE], with a history of delirium and confusion due to a diagnosis of hepatic encephalopathy (a loss of brain function as a result of failure in the removal of toxins from the blood due to liver damage). Review of Resident CI1's admission Minimum Data Set (MDS- an assessment of care needs) dated February 15, 2024, indicated that the resident had moderately impaired cognition. The assessment also indicated that Resident CI1 was exhibiting behaviors of inattention and disorganized thinking. Review of Resident CI1's CI1's physician notes dated February 28, 2024 indicated that Resident CI1 had increased anxiety and pacing behaviors. The resident had several elopment attempts from the facility, requiring a wanderguard (alarming device to the right ankle). The resident confirmed the increased anxiety and wanting to punch somebody. The resident was reporting to the physician that he used alcohol three to four times a week. The physician indicated that this resident was oriented to name only with an anxious mood and behavior agitated when approached. The physician wanted psychiatry to exam and treat this resident. Clinical record review revealed that the physician gave orders on February 8, 2024, February 13, 2024, February 27, 2024 and February 29, 2024 for psychiatry and psychology consults for Resident CI1. Interview with the Director of Nursing, Employee E2, on March 7, 2024 at 10:30 a.m., confirmed that the facility had not consulted the psychiatry or psychology department's staff to assess, evaluate and treat Resident CI1 as ordered by his attending physican on February 8, 2024, February 13, 2024, February 27, 2024 and February 29, 2024. 28 Pa Code 211.10 (c) Patient care policies 28 Pa. Code 211,12(d)(1)(3) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on a review of clinical records, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility related to to the proper discharge on one of three residents reviewed (Resident CI1) and resulted in an Immediate Jeopardy situation. Findings include: Review of the job description for the Nursing Home Administrator revealed, The Administrator is responsible for directing the day-to-day functions of the facility in accordance with current federal, state and local standards governing long-term care facilities to ensure that the highest degree of quality resident care and services are delivered and maintained. He/she will ensure all personnel are treated fairly and consistent with company policy and applicable laws .Ensures that each resident received the necessary nursing, medical, and psychological services to attain and maintain the highest possible mental and physical functional status . Interprets and ensures compliance with all facility policies and procedures by all employees, residents, families, visitors, government agencies and the general public .Ensures that timely notice is given and strictly followed for resident discharges and room and/or roommate changes. Review of the job description for the Director of Nursing revealed The Director of Nursing is responsible for assisting the Executive Director in the implementation and attainment of Nursing Department goals and objectives. He/she will direct the operations and staff of the Nursing Department, providing leadership, direction and evaluation of the delivery of nursing care and services within program models and ensuring strict compliance with Hospital, Federal, State and local regulatory requirements. Review of Resident CI1's clinical record revealed that the resident was admitted on [DATE], with a history of delirium and confusion due to a diagnosis of hepatic encephalopathy (a loss of brain function as a result of failure in the removal of toxins from the blood due to liver damage). Review of nursing progress note dated February 9, 2024, indicated that Resident CI1 was showing symptoms of unsteady gait and voiding on the floor; the resident said the reason for the voiding on the floor was because he had a hernia. The nursing note also stated that Resident CI1 was frustrated because he could not get the proper words to speak. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident Cl1's admission Minimum Data Set (MDS- an assessment of care needs) dated February 15, 2024, indicated that the resident had moderately impaired cognition. The assessment also indicated that Resident Cl1 was exhibiting behaviors of inattention and disorganized thinking. The resident was noted saying that it was very important for family or close friend to be involved in discussion about his care. The assessment indicated impairment or limitations to funtional abilities for Resident Cl 1 of bilateral lower extremity impairments, with a need for a mobility device. Resident Cl1 required supervision, touching and cueing from staff, for safe transfers and to safely position from sitting to standing. The resident was occasionally incontinent of urine and frequently incontinent of bowel. Review of Resident C11's care plan initiated February 14, 2024, revealed that the resident was identified with a history of delirium or an acute confusion episodes related to metabolic/hepatic encephalopathy. The interventions included to monitor the resident's safety every shift. Continued review of the resident's care plan revealed that the resident was care planned for symptoms that increase safety risk which included confusion, delirium, dizziness and for the potential for fall related to a decline in functional statues. On February 28, 2024, a care plan was initiated for the resident having the potential for elopement related to exit seeking behavior. The interventions included to check resident's whereabouts frequently, make receptionist and other staff aware of elopement risk and notify social services for persistent attempts to leave building and not responding to redirection. On February 29, 2024, the intervention of wanderguard (alarming device that locks doors specific doors to prevent the resident for leaving the building) to right ankle was initiated. Review of physician's notes dated February 28, 2024, indicated that Resident Cl1 had increased anxiety and pacing behaviors. The resident had several elopement attempts from the facility, requiring a wanderguard. The resident confirmed the increased anxiety and wanting to punch somebody. The resident was reporting to the physician that he used alcohol three to four times a week. The physician indicated that this resident was oriented to name only with an anxious mood and behavior agitated when approached. The physician wanted psychiatry to exam and treat this resident. Review of the Speech/Language/Swallowing Pathologist's notes dated March 1, 2024, revealed that the therapist was evaluating Resident Cl1 and determined that his cognition level was moderately impaired. The note indicated that the therapist had to provide moderate cues with memory compensatory strategies for the resident to recall dates, times. The therapist indicated that Resident Cl1 was extremely erratic with moments of aggression during therapy. Review of Physical Therapist's note dated February 28, 2024, revealed that Resident Cl1 was using hand held assistance and supervision of one staff member for ambulation. Review of nursing note dated March 4, 2024, revealed that Resident Cl1 left the facility, because he was requesting to leave the facility. The nursing note indicated that the resident was ambulating as he left the facility. Interview with the Director of Nursing, Employee E2 on March 7, 2024, at 2:00 p.m., revealed that the wanderguard was removed from Resident Cl1's right ankle on March 4, 2024; so that Resident Cl1 could ambulate out the front entrance of the facility, without triggering the alarm system. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator, Employee E1, on March 7, 2024, at 2:30 p.m., confirmed that Resident CI1 had ambulated out the entrance of the facility. The Nursing Home Administrator, Employee E1 also confirmed that the facility had no idea of Resident CI1's whereabouts. Interview with the Nursing Home Administrator, Employee E1, Director of Nursing, Employee E2 and Social Worker, Employee E6 at 9:00 a.m., on March 8, 2024, revealed that Resident CI1 was asked to sign and date a release for discharge against medical advice form on March 4, 2024. Review of this form revealed that a signature; however, no date was completed. Interview with the Director of Nursing, Employee E2 and the Social Worker, Employee E6, on March 8, 2024, at 9:30 a.m., revealed that prior to discharge of Resident CI1 on March 4, 2024, there was no contact with the resident's physician's about anticipated discharge planning. Employees E2 and E6 also confirmed that before discharge of Resident CI1, who was cognitively impaired, there was no contact with the resident's family and responsible party. Employees E2 and E6 confirmed during this interview that the office of the State Long Term Care Ombudsman was not notified before resident CI1's discharge on March 4, 2024. Employees E2 and E6 also confirmed during the interview that the agency responsible for the protection and advocacy of mental disorders was not notified about the discharge of Resident CI1 from the facility on March 4, 2024. Interview with the Licensed nurse, Employee E23, on March 8, 2024 at 10:00 a.m., revealed that this nurse was not aware on March 4, 2024 that Resident CI1 left the facility alone and without an address or specific location to which he was discharged . The licensed nurse, Employee E23 stated that the resident's belongings (identification cards license and credit cards) were in the nursing medication cart. Licensed nurse, Employee E23 who was familiar with Resident CI1 was concerned for his welfare being discharge with no walker; since he was at risk for falls, no medications, no safe place to live with food and water, no money and no friend or family contact or means of contacting friends, family or public help. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate jeopardy situation. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management