STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555259	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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 - Minimal harm or potential for actual harm 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** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to implement their P&P regarding the AMA discharge for one of two sampled residents (Resident 1). * The facility failed to provide the appropriate instructions including to contact the physician immediately when Resident 1 was AMA discharged as per the facility's P&P. In addition, the physician was not informed of the resident wanting to leave AMA until after the resident had left the facility. These failures had the potential to place Resident 1 at risk for medical complications post-discharge. Findings: Review of the facility's P&P titled Discharge Against Medical Advice revised 5/2007 showed to ensure the safe departure from the facility when it is without medical approval, give any appropriate instructions to the resident, and instruct to contact the physician immediately; and document instructions given on the record. Closed medical review for Resident 1 was initiated on 3/26/24. Resident 1 was admitted to the facility on [DATE], and left the facility AMA on 2/13/24. Resident 1 had a diagnosis of diabetes mellitus with ketoacidosis, dementia, Alzheimer's disease, and psychosis. Review of Resident 1's MDS section A1510 Level II Preadmission screening and Resident Review (PASRR) Conditions dated 2/9/24, showed Resident 1 [NAME] serious mental illness. Review of Resident 1's H&P examination dated 1/31/24, showed the following: - Resident 1 had fluctuating capacity to understand and make medical decisions. - Resident 1 had a surrogate decision maker (Caregiver 1). - Resident 1's caregiver (Caregiver 1) planned on transitioning the resident to an assisted living facility as she could no longer care for him at home. - Social services for placement options. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 1's plan of care showed all of the above were discussed with the patient, family member, and facility staff. Review of Resident 1's Nursing Notes dated 2/13/24 at 1330 hours, showed Resident 1 was informed his leave of absence would be AMA, and the facility could not provide his medications and home health services. Resident 1 left the facility AMA. Review of Resident 1's physician's orders showed an order dated 2/13/24 at 1332 hours, for Resident 1's AMA discharge and Caregiver 1 was notified. Review of Resident 1's Nursing Notes dated 2/13/24 at 1430 hours, showed Resident 1 came back to the facility to pick up his belongings. Review of Resident 1's Nursing Notes dated 2/13/24 at 1445 hours, showed the Case Manager and DON called the Uber services to transport Resident 1 to Caregiver 1's home. Review of Resident 1's Nursing Notes dated 2/13/24 at 1523 hours, showed Caregiver 1 was notified that Resident 1 returned to pick up his belongings from the facility. Caregiver 1 stated Resident 1 arrived at her home but left again. Further review of the closed medical record showed no documented evidence both the resident and Caregiver 1 were given the appropriate instructions including to contact the physician immediately as per the facility's P&P. There was no documented evidence the physician was informed of the resident wanting to leave the facility AMA until after the resident had left the facility. On 3/26/24 at 1358 hours, an interview was conducted with the Nursing Supervisor. When asked how the facility handled the residents who wanted to leave AMA and with no mental capacity, the Nursing Supervisor stated the physician and immediate family member must always be notified. The residents could not just leave if they were not alert and oriented, so the facility would ensure the family member would be there to assist the resident. On 3/26/24 at 1500 hours, an interview was conducted with the SSD. The SSD stated Resident 1 was not provided any discharge instructions because he left AMA. The SSD further verified Caregiver 1 was not provided any discharge instructions. On 3/29/24 at 1216 hours, an interview was conducted with the DON. The DON verified Resident 1's physician and Caregiver 1 were not notified of Resident 1's AMA discharge until after it occurred. The DON stated when it was happening, they wanted to make sure to deal with Resident 1 first. On 3/26/24 at 1535 hours, an interview was conducted with RN 1. RN 1 stated she spoke to Caregiver 1 and informed her that Resident 1 left against medical advice. RN 1 stated Caregiver 1 did not sound happy, stating you guys are sending him back here and he left again. RN 1 stated Caregiver 1 verbalized she could not take care of Resident 1 because he was uncontrollable, and she did not sound agreeable to haveResident 1 coming back to her home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 1129 hours, an interview and concurrent closedrecord review was conducted with the DON. The DON verified the Case Manager called a transportation service on 2/13/24. The DON assisted in transporting Resident 1 to Caregiver 1's home because Resident 1 verbalized he wanted to go to Caregiver 1's home. The DON stated she was unaware Caregiver 1 had informed the facility she could not take care of Resident 1. The DON verified Resident 1's H&P examination dated 1/30/24, showed Caregiver 1 had planned on transitioning the resident to an assisted living because she could no longer care for him at her home.