| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555565 | A. Building<br>B. Wing | 05/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Artesia Palms Care Center | 11900 E. Artesia Blvd.<br>Artesia, CA 90701 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537<br><br>Based on interview and record review, the facility failed to ensure, a resident, who lacked the capacity to understand and make decisions, was not discharged from the facility against medical advice ([AMA] choosing to leave the hospital before the treating physician recommends discharge) for one of 141 residents (Resident 1).<br><br>The facility failed to:<br><br>1. Ensure Resident 1 was competent to make a decision to leave the facility and sign out AMA.<br><br>2. Ensure Resident 1 had a valid Out On Pass ([OOP] temporary permission given to a resident to leave the facility for a specified amount of time) and AMA order on 4/19/2024, the day Resident 1 wanted to leave.<br><br>3. Assess Resident 1's ability to understand his medication regimen in order to safely take his prescribed Haldol (medication for treating schizophrenia [a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others]) for paranoid delusion (profound fear and anxiety [Intense, excessive, and persistent worry and fear about everyday situations] along with the loss of the ability to tell what's real and what's not real) before providing Resident 1 with a total of 41 tablets of Haldol 10 milligrams ([ mg] a unit of measurement of weight) at the time of discharge AMA on 4/19/2024.<br><br>4. Ensure there was a referral (preadmission arrangements) made to the shelter before allowing Resident 1 to leave the facility AMA, placing him into a ride-share (a service or network through which ride-sharing trips are arranged) vehicle and sending him to the shelter.<br><br>5. Prior to discharge, notify Resident 1's Responsible Party (RP) that Resident 1 was going to sign out of the facility AMA and would be going to a shelter on 4/19/2024.<br><br>(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 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | These deficient practices resulted in Resident 1 leaving the facility without prior arrangements, to the shelter of his choice. Resident 1 was not accepted by the shelter upon Resident 1's arrival to the shelter and is now missing. Resident 1's whereabouts are currently unknown. These failures placed Resident 1 at a high risk for exposure to harsh environmental conditions, possible motor vehicle accidents, and medical complications due to taking antipsychotic medications (medications work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking) inappropriately, or overdosing (too much of a drug taken or given at one time), malnutrition (lack of proper nutrition), heart failure, chronic kidney disease complications, dehydration (body doesn't have as much fluid as it needs), and possible death.<br><br>On 4/26/2024 at 3:02 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation caused, or was likely to cause serious injury, harm, impairment, or death to a resident) related to failure to safely discharge a psychiatric resident (Resident 1) with a 20-days supply of medications without assessing the resident's ability to self-administer his prescribed antipsychotic (medication that affects the brain) medication was called in the presence of the Administrator, the Director of Nursing (DON) and two outside Resource Registered Nurses.<br><br>The facility submitted an acceptable IJ removal plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed on 5/1/2024 at 8:41 a.m., in the presence of the temporary manager and Assistant Director of Nursing (ADON).<br><br>The IJRP included the following:<br><br>1.On 4/26/2024 the Medical Director reviewed and approved the updated changes to the Policy and Procedure for Out on Pass, to include, residents' discharge, and measures to take if a resident is out on pass and refuses to return to the facility on [DATE].<br><br>2.The Medical Director approved the updated changes to the Policy and Procedure for Discharging a Resident Without a Physician's approval (Against Medical Advice-AMA) on April 30, 2024.<br><br>3.The facility began In-service (education) training for Social Services and Licensed Nurses on Policies and Procedures for the following; Out On Pass, Safe Discharge AMA, beginning on April 30, 2024, by the Director of Nursing/Designee to be completed when employees return to work according to their schedule.<br><br>4.At the time of admission, the physician will make the decision regarding the capacity (ability of the resident to make decisions).<br><br>The results of the capacity determination will identify if the resident is responsible for decision making. The facility will ascertain if the resident has a responsible party or not, prior to admission. A new policy and procedure will be implemented for capacity. The Admission Packet includes the resident's capacity for making decisions and the responsible party who signs on behalf of the resident.<br><br>5.Physicians will be asked to reassess their residents' capacity status as needed.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 6.The Out On Pass Policy was updated to state that if a resident is refusing to return to the facility from out on pass activity, residents' responsible party, primary MD and Psychiatrist will be notified.<br><br>7.Every effort will be made by the staff to assist the resident to return to the facility. They will have a conversation with the resident on why they do not want to return to the facility. Social Services, the Administrator and Director of Nursing will be notified.<br><br>8.If the resident is suspected to be a danger to self or others appropriate authorities will be notified to determine if a 5150 hold (an involuntary hold of a person who is deemed to be a danger to themself, a danger to others, or gravely disabled, as a result of a mental disorder, for psychiatric evaluation, assessment, and/or treatment) will be placed and the resident will be transferred to a psychiatric (mental illness) acute (sudden) care hospital for further evaluation. If the resident is determined not to be a danger to self or others, he/she will be educated on the risks and benefits of leaving the facility against medical advice (AMA). As, it is the Residents Right to leave the facility AMA, the staff will follow guidelines of AMA policy and procedure.<br><br>9. The facility began In-service training for Social Services staff and Licensed Nurses on Policies and Procedures for the following; Out On Pass, Safe Discharge AMA, beginning on April 30, 2024, by the Director of Nursing/Designee to be completed as employees return to work according to their schedule.<br><br>10. A facility wide Capacity/Responsible Party (a person that would make decisions for Residents that cannot safely make their own decisions) audit was conducted on April 26, 2024, to determine if there were any other residents found to have unknown responsibility status. At this time all residents have capacity identified and the Responsible Party identified. An audit was conducted by Social Services for other residents if they have fluctuating capacity (a person whose decision-making ability varies). 18 residents were identified with fluctuating capacity. Out of the 18 identified, six residents did not have capacity status (to make decisions); they were referred to the public guardian (a public official that is responsible for the care of individuals who are no longer able to make decisions or care for themselves). Four of those are still being processed and two have been processed and will move forward through the public guardian appointing process. Their physicians will be notified to reassess if they have capacity to make decisions on a quarterly basis.<br><br>11. The care plans for those residents with fluctuating or no capacity will be revised to reflect the residents' capacity by Friday May 3rd, 2024.<br><br>12.The resident's physician will be notified of the request for AMA discharge. The physician will determine the need to release the resident AMA with or without medications. If the resident does not have capacity, they will not be sent with medications unless there is a Responsible Party present to take responsibility for the medication. If the resident is released with medications and it is expected that they will self-administer those medications, an assessment of the resident, will be conducted by the nursing staff to assure they have the ability to accurately self-administer those medications.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 13. Any resident who discharges AMA will be trained on self- administration of medications before they leave the facility. A Discharge Summary will be given to the resident with the directions for taking the medications. The resident will sign the Discharge Summary indicating that they have received self-medication administration training and understand the risks and benefits of taking the medications correctly. The facility staff will also sign the Discharge Summary, witnessing the resident's signature. The progress note will include all steps taken to foster the resident's highest practicable wellbeing because of the resident going out of the facility AMA.<br><br>14. Licensed nurses will be in-serviced on the policy and procedure for self-administration of medications, training on self-administration of medications and disposition of remaining medications beginning on April 30, 2024, by the Director of Nursing/Designee using the teach back method by May 3rd, 2024, or upon their next scheduled shift. Medications not given to the resident upon AMA discharge will be disposed of according to State and Federal regulations.<br><br>15. The facility will ensure that any resident who leaves the facility AMA is given the best chance possible of succeeding outside of the facility by notifying the receiving facility, including shelters, the resident has requested to move to and that the shelter would be able to meet their needs. Social Services and licensed nurses will be in-serviced on notifying the intended location, assuring availability and capability to meet resident needs. Social Services will be responsible for notifying any shelter of the resident's request. Social Services will be in-serviced on Discharging a Resident Without a Physician's approval (Against Medical Advice-AMA) beginning on April 30, 2024, by the Director of Nursing/Designee to be completed by May 3rd, 2024.<br><br>16. Social Services will be responsible for follow-up on any resident who went AMA to see if they arrived at their intended location, where practicable. Social Services and Licensed nurses will be in-serviced beginning on April 30, 2024, by the Director of Nursing/Designee to be completed by May 3rd, 2024.<br><br>17. The facility has begun an audit of all residents with the inability to make decisions. Conservators (a person who looks after and is legally responsible for someone who is unable to manage their own affairs)/Responsible Party will be notified if one of their residents tries to seek a discharge (AMA). That is the conservator's/ Responsible Party's responsibility to make that decision. The facility will follow the conservators' decisions. The facility will follow its' policies and procedures for AMA Discharge and notification of Responsible Parties pending AMA discharge.<br><br>18. Action Plans to manage reoccurrences of leaving the facility against medical advice (AMA) will be implemented in the Quality Assurance and Performance Improvement Committee ([QAPI] a facility committee consisting of department heads, the medical director, physicians and key staff that identifies system failures by data gathering and analysis and implements measure to improve the overall quality of life and quality of care and services delivered to nursing home residents.) on April 29, 2024.<br><br>Findings:<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a review of Resident 1's General Acute Care Hospital (GACH 1) Behavioral Health Progress Note dated 2/25/2024, the Behavioral Health Progress Note indicated, Resident 1 exhibited signs of paranoia (unjustified suspicion and mistrust of other people and/or their actions) and was brought to GACH 1 from a jail, with disorganized thoughts, and poor insight. The Behavioral Health Progress Note indicated Resident 1 was a poor historian, unkempt (having an untidy appearance), malodorous (an unpleasant or offensive odor), and with disorganized speech, and on a 5150 hold. The Behavioral Health Progress Note indicated Resident 1 had two recent psychiatric evaluations in the past two months and ongoing intractable (not easily controlled or directed) psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality).<br><br>During a review of Resident 1's Order Summary Report (OSR), from the SNF, dated 4/24/2024, the OSR indicated, to admit Resident 1 to the facility on [DATE].<br><br>During a review of Resident 1's Skilled Nursing Facility (SNF) Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia, congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), myocardial infarction ([heart attack] when the heart muscle begins to die because it isn't getting enough blood flow), anxiety disorder, obstructive sleep apnea (a disorder in which a person frequently stops breathing during his or her sleep), and essential hypertension ([HTN] abnormally high blood pressure that's not the result of a medical condition).<br><br>During a review of Resident 1's History and Physical (H&P), dated 3/15/2024, the H&P indicated, Resident 1 had a fluctuating capacity to make decisions.<br><br>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/20/2024, the MDS indicated Resident 1 required assistance (helper does all of the effort) from one staff for toilet use, hygiene, lower body dressing, putting on/taking off footwear, bed mobility, and transfers. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from one staff for personal hygiene, moderate assistance (helper does less than half the effort) from one staff for upper body dressing, oral hygiene, rolling from left to right, and supervised touch assistance (helper provides verbal cues/touching/steadying/contact guard assistance) from one staff for eating and showering.<br><br>During a review of Resident 1's Change in Condition Evaluation/Change of Condition (COC) dated 3/4/2024 and timed at 6 p.m., the COC indicated, upon admission Resident 1 was verbally aggressive and attempted to strike at staff and was requesting to leave the facility. The COC indicated a physician's order was obtained to transfer Resident 1 on a 5150 hold to GACH 2 for further evaluation.<br><br>During a review of Resident 1's Order Summary Report dated 4/24/2024, the OSR indicated, a physician's order dated 3/4/2024 to transfer Resident 1 to GACH 2 for evaluation and treatment related to paranoid delusion.<br><br>During a review of Resident 1's GACH 2 H&P, dated 3/5/2024, the H&P indicated, Resident 1 was brought to GACH 2's emergency department (ED) on a 5150 hold for further treatment, after developing acute agitation and striking out at staff members.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a review of Resident 1's Order Summary Report, from the SNF, dated 4/24/2024, the Order Summary Report indicated, a physician's order dated 3/13/2024 to admit Resident 1 to the facility.<br><br>During a review of Resident 1's Summary of Neurobehavioral and Cognitive (an assessment of a wide range of mental functions, including behavior, to see how well the brain works) consult, dated 4/12/2024, the Neurobehavioral Summary indicated Resident 1 was partially oriented (he did not know the month and the year), with partial awareness of his location, and was unable to express himself verbally. The Summary Neurobehavioral Consult note indicated Resident 1 had difficulty making complex decisions and the help of a designated decision-maker was recommended.<br><br>During a review of Resident 1's Interdisciplinary Team [([IDT] - a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological, and spiritual needs of the resident) Conference Notes, dated 3/13/2024, the IDT Conference Notes indicated, Resident 1 was to remain in the facility at this time. The IDT Conference Notes indicated Resident 1 wished to transition back to community and he would be referred to ancillary (supportive or diagnostic measures that supplement and support a primary healthcare provider in treating a patient) services and psychology for follow up.<br><br>During a review of Resident 1's Order Summary Report dated, 4/24/2024, the Order Summary Report indicated a physicians' order dated 3/13/2024 to give Haldol 10 mg, one tablet by mouth, two times a day for schizophrenia manifested by paranoid delusions.<br><br>During a review of Resident 1's Order Summary Report dated, 4/24/2024, the Order Summary Report indicated a physician's order dated 3/31/2024 to give Ativan one mg, one tablet by mouth, every six hours as needed for anxiety disorder for 14 days as manifested by the inability to relax.<br><br>During a review of Resident 1's Medication Administration Record (MAR), the MAR indicated Resident 1 received Ativan 1 mg for anxiety on the following days:<br><br>1. 3/15/2024 at 4:15 p.m.<br><br>2. 3/16/2024 at 6:00 p.m.<br><br>3. 3/17/2024 at 9:56 p.m. and 6:00 p.m.<br><br>4. 3/18/2024 at 10:01a.m. and 6:05 p.m.<br><br>5. 3/20/2024 at 5:15 p.m.<br><br>6. 3/21/2024 at 5:20 p.m.<br><br>7. 3/22/2024 at 5:30 p.m.<br><br>8. 3/23/2024 at 6:00 p.m.<br><br>9. 3/24/2024 at 5:03 p.m.<br><br>10. 3/27/2024 at 5:00 p.m.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 10. 4/2/2024 at 4:27 p.m.<br><br>11. 4/5/2024 at 4:27 p.m.<br><br>12. 4/11/2024 at 9:28 p.m.<br><br>During a review of Resident 1's Self-Administration of Medication observation form, dated 3/13/2024, the Self-Administration of Medication Observation form indicated, Resident 1 did not want to self-administer medication.<br><br>During a review of Resident 1's OOP order, created by the Assistant Director of Nurses (ADON) on 4/19/2024 and a back -date (to date the order earlier than it was actually given) of 3/20/2024, the OOP order indicated Resident 1 could leave the facility on a therapeutic pass, in the company of a facility staff member for safety and supervision.<br><br>During a review of Resident 1's AMA order, created by the Director of Nursing (DON) on 4/22/2024 (back-dated three days after Resident 1 left the facility AMA), the AMA order indicated Resident 1 may be discharged from the facility AMA on 4/19/2024.<br><br>During a review of Resident 1's clinical record, the clinical record indicated there was no OOP order on 4/19/2024 (the day Resident 1 was accompanied by facility staff OOP).<br><br>During a review of Resident 1's Ride-Share receipt, dated 4/19/2024, the Ride Share receipt indicated Resident 1 was picked up at the bus stop near the sidewalk of the fast-food restaurant at 1:52 p.m., and arrived at the destination (shelter) at 2:10 p.m.<br><br>During a review of Resident 1's Social Service Notes (SSN), dated 4/23/2024 and timed 9:50 p.m., the SSN indicated, the Social Service Director (SSD) contacted the shelter Resident 1 was sent to, and spoke to the shelter coordinator. The SSN indicated the shelter coordinator stated there was no record of Resident 1 checking in to the shelter as of 4/19/2024.<br><br>During an interview on 4/23/2024, at 3:40 p.m., the SSD stated he was not informed that Resident 1 signed out of the facility AMA until after the incident. The SSD stated, many shelters required a referral due to limited space and had he known Resident 1 was being discharged from the facility he could have assisted him to find a place to transfer to. The SSD stated he should have followed up with the shelter Resident 1 was transferred to, to make sure Resident 1 arrived and was admitted there. The SSD stated, some shelters could assist residents with limited medical care, he did not know if the shelter that Resident 1 was sent to could accommodate Resident 1's medical needs or if they would administer Resident 1's medications. The SSD stated there was no discharge plan for Resident 1 because Resident 1 had been transferred in and out of the facility to the GACH on a 5150 hold because of behavioral issues.<br><br>During an interview on 4/23/2024, at 4:03 p.m., Licensed Vocational Nurse (LVN 1) stated Resident 1 was usually quiet and cooperative, but there were times when he became verbally aggressive and paranoid. LVN 1 stated that was why Resident 1 was on routine (scheduled) Haldol and as needed Ativan. LVN 1 stated, Resident 1 had a history of noncompliance with taking his medication, and his daily medications were administered by the licensed nurses at the facility and Resident 1 never expressed a desire to self-administer his medications.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 4/23/2024, at 4:41 p.m., Registered Nurse Supervisor 1 (RNS 1) stated, Resident 1 was transferred to GACH 2 on 3/4/2024 because of aggressive behavior and was readmitted to the facility on [DATE] to a secured unit (a unit in a nursing home that restricts a resident's ability to freely move in and out of ) for behavior monitoring, but was transferred from the secured unit to a skilled nursing unit (non-secured unit with less intense monitoring for behavior issues and focuses on medical and rehabilitation treatment) on 4/16/2024. RNS 1 stated Resident 1 had a fluctuating mental capacity, and he might not understand the risks of AMA and stated she was not sure if Resident 1 was safe to leave the facility AMA.<br><br>During a telephone interview on 4/24/2024, at 8:46 a.m., Family Member (FM 1) stated, no one at the facility called to notify her that Resident 1 wanted to leave the facility or that Resident 1 left the facility AMA. FM 1 stated, Resident 1 was not in his right mind, and she could not understand how the facility let Resident 1 leave the facility even if he wanted to go, or how the sheriff, who were not medical professionals, could assess someone's mental capacity.<br><br>During an interview on 4/24/2024, at 10:49 a.m., the ADON stated he took Resident 1 OOP on 4/19/2024 to a fast-food restaurant across the street from the facility. The ADON stated, after Resident 1 ordered and got some food Resident 1 started walking outside of the fast-food restaurant and refused to go back to the facility. The ADON stated, he notified the DON, the Administrator (ADM), and a Registered Nurse that worked with a temporary management team (TMRN 1) that was contracted with and stationed at the facility. The ADON stated TMRN 1 instructed him to call the local sheriff department to evaluate Resident 1 for a 5150 hold, to notify Resident 1's psychiatric (Psychiatrists are trained physicians who specialize in evaluating, diagnosing and treating mental disorders) doctor and follow whatever the psychiatrist asked him to do.<br><br>During an interview on 4/24/2024, at 11:00 a.m., the ADON stated, he spoke to Resident 1's psychiatrist via the telephone and received an order from him to sign Resident 1 out AMA if the sheriff did not place Resident 1 on a 5150 hold. The ADON stated, the sheriff reported that Resident 1 did not meet the criteria for a 5150 hold, so he (ADON) believed Resident 1 was safe to be discharged AMA, as instructed by Resident 1's psychiatrist. The ADON stated, there was an order in place on 4/16/2024 which indicated Resident 1 could go out to the courtyard (which was an outside common area on facility grounds surrounded by the facility buildings) for therapeutic services. The ADON stated, the fast-food restaurant was across the street from the facility, so he took Resident 1 to the fast-food restaurant. The ADON stated he did not assess Resident 1's behavior prior to taking him across the street to the fast-food restaurant to determine if it was safe for him to go OOP that day.<br><br>During an interview on 4/24/2024, at 11:15 a.m., the ADON stated, he did not know the shelter (Resident 1 chose to go to) required a referral and thought anyone could just walk in and get accepted, nor did he follow up with the shelter to see if Resident 1 arrived there safely. The ADON stated he should have consulted with the SSD for Resident 1's placement, but he did not, and he did not call FM 1 or FM 2 during the process prior to Resident 1 leaving AMA, he only left a message with FM 1 after Resident 1 had already left the facility AMA. The ADON stated he did not notify FM 1 or FM 2 that Resident 1 was not accepted at the shelter or that Resident 1's current location was unknown because he did not follow up with the shelter and did not know Resident 1 was not there.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555565 | A. Building<br>B. Wing | 05/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Artesia Palms Care Center | 11900 E. Artesia Blvd.<br>Artesia, CA 90701 |

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) |
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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a telephone interview on 4/24/2024, at 11:29 a.m., Resident 1's psychiatrist stated, he did not think Resident 1 had the capacity to make decisions, but it did not matter whether he had capacity or not, it was his right to leave AMA if the sheriff did not place him on a 5150 hold. Resident 1's psychiatrist stated he told the facility to give Resident 1 a 10 day-supply of Haldol 10 mg tablets because he did not want Resident 1's medication to be stopped abruptly to prevent relapse (reoccurrence) of psychosis (a severe mental condition in which thoughts and emotions are so affected and contact is lost with reality). Resident 1's psychiatrist stated there was the risk of overdose if Resident 1 took to many Haldol tablets, which could lead to arrythmia (a condition in which the heart beats with an irregular or abnormal rhythm which may increase the risk for a serious heart condition).<br><br>During an interview on 4/24/2024, at 11:44 a.m., LVN 3 stated, she received a call from the ADON asking her to bring an AMA form and all Resident 1's medications to the sidewalk near the fast-food restaurant. LVN 3 stated she gave all of Resident 1's medications and AMA form for Resident 1 to sign, to the ADON.<br><br>During a telephone interview on 4/24/2024, at 11:56 a.m., the Referral Agent (RA) at the shelter Resident 1 was sent to stated, Resident 1 showed up at the shelter on 4/19/2024, but they could not admit him because he did not have a referral from the facility, he came from, prior to arriving at the shelter and they only accept walk-ins if they had enough beds available. The RA stated Resident 1 came in after 2 p.m., when available beds had already been assigned by that time. The RA stated Resident 1 left the shelter after he was told he could not check in and he (RA) did not know where Resident 1 went or his whereabouts.<br><br>During an interview on 4/24/2024, at 1:48 p.m., the DON stated he was not sure if there was an OOP order for Resident 1 prior to 4/19/2024 and he did not create an AMA order until after Resident 1 left the facility (4/22/2024) because he got busy and forgot to do it. The DON stated, he received a call from the ADON on 4/19/2024 regarding Resident 1's refusal to come back to the facility. The DON stated he went with the ADM to the sidewalk of the fast-food restaurant to assist the ADON with discharging Resident 1. The DON stated, he gave Resident 1 a total of 41 tablets of Haldol 10 mg which was a 10-day supply. (According to the Resident 1's physicians' order dated 3/13/2024 to administer Haldol 10 mg, one tablet by mouth, two times a day for schizophrenia manifested by paranoid delusions, the DON gave Resident 1 a 20-day supply of Haldol).<br><br>During an interview on 4/24/2024, at 2:00 p.m., the DON stated, he did not check Resident 1's Self-Administration of Medication Assessment nor did he give Resident 1 written instructions related to his Haldol. The DON stated Resident 1 responded OK when he showed him the instructions on the Haldol package on how to take his medication. The DON stated, he forgot to document Resident 1's medication order to give Resident 1 a 10-day supply of Haldol on the eMAR (a digital version of the MAR), or in Resident 1's Medication Disposition Log (any medication dispositioned or supplied to the resident should be documented on medication disposition log for record keeping).<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 4/24/2024, at 2:05 p.m., the DON stated, he did not know if anyone at the shelter would supervise Resident 1's Haldol self-administration. The DON stated, Resident 1 could be at risk for overdose if he took to many of the Haldol tablets at one time or his symptoms could worsen if Resident 1 did not take the Haldol. The DON stated, it was not safe to discharge Resident 1 but Resident 1 was the one who made the decision to leave the facility AMA. The DON stated, he did not know the shelter required a referral from the facility for Resident 1 to be admitted , had he known that he would have called the shelter with a referral to have Resident 1 admitted . The DON stated, he was not familiar with the facility's AMA policy for residents with mental illness.<br><br>During a telephone interview on 4/24/2024, at 6:25 p.m., FM 1 stated, Resident 1 had been suffering from mental illness and other medical conditions for over [AGE] years and had been in and out of hospitals all of those years for his behaviors. FM 1 stated she received a voice-message from facility staff during the evening of 4/19/2024, when she called back the next morning (4/20/2024) the facility nurse told her Resident 1 left the faciity on [DATE] because he did not want to stay at the facility. FM 1 stated, the facility did not tell her Resident 1 was not accepted to the shelter he was sent to, and that his whereabouts were unknown. FM 1 stated she was scared that Resident 1 would harm himself or someone else, based on her previous experience with him, and she was worried about his safety.<br><br>During an interview on 4/25/2024, at 4:42 p.m., the ADM stated, he received a call from the ADON that Resident 1 refused to come back to the facility while her and Resident 1 were OOP at a fast-food restaurant across the street from the facility. The ADM stated, they followed the instructions of Resident 1's psychiatrist and TMRN 1 to discharge Resident 1 AMA. The ADM stated, they could have done better, but the situation was very intense at that time, and they did not have all of Resident 1's previous psychiatric history. The ADM stated, they should have contacted the SSD to arrange placement for Resident 1 before discharging him AMA and they should have followed up with the shelter to see if Resident 1 was admitted . The ADM stated their policy was not very clear about the process and requirements for AMA.<br><br>During a telephone interview on 4/27/2024, at 9:51 a.m., Resident 1's psychologist (a person who specializes in the treatment of mental, emotional, and behavioral disorders without prescribing medications) stated, he was not aware that Resident 1 was released from the facility AMA. Resident 1's psychologist stated Resident 1 could not make complex decisions and he was concerned Resident 1 would become noncompliant with his care and not take his medication as he had done in the past, which would make his condition worse.<br><br>During a review of the facility's P&P titled, Transfer or Discharge, Emergency, revised 8/2018, the P&P indicated, should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will notify the resident's attending physician, notify the receiving facility that the transfer is being made, notify the representative (sponsor) or other family member.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Discharging a Resident Without a Physician's Approval, revised 10/2022, the P&P indicated, if a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location, document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed, document that despite being [TRUNCATED] |