STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40537 Based on interview and record review, the facility (Skilled Nursing Facility 1 [SNF 1]) failed to protect the resident ' s right to be free from neglect (the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress) for one of three sampled residents (Resident 1), when the facility discharged Resident 1, who exhibited behaviors that made Resident 1 a danger to himself (Resident 1) and others, and who was admitted to SNF 1, a locked facility (facility that cares for residents that utilize secured perimeter fences or locked exit doors) to SNF 2, a non-locked facility (a facility that does not have secured or locked units) on [DATE] without providing safe and orderly discharge services by: 1. Failing to ensure Registered Nurse 2 (RN 2) obtained a physician order from Medical Doctor 1 (MD 1-Resident 1 ' s attending physician) to discharge Resident 1 to SNF 2 on [DATE]. 2. Failing to ensure that the facility staff at SNF 1 provided SNF 2 with the discharge summary and recapitulation of stay (a summary of a resident course of treatment and stay at a facility) for Resident 1 when Resident 1 was discharged to SNF 2 on [DATE]. SNF 2 was only provided the Order Summary Report (a list of the physician orders for a resident, while the resident was admitted to a facility). 3. Failing to ensure facility staff from SNF 1 conducted a hand off communication (the transfer of resident medical information from the licensed nurse of the discharging facility to the licensed nurse of the receiving facility for continuity of care) to SNF 2 in preparation of receiving and admitting Resident 1 on [DATE]. 4. Failing to ensure facility staff established or specified the specific care that Resident 1 needed that SNF 1, a locked unit was unable to provide, that required Resident 1 to be discharged to SNF 2, an unlocked and less secure unit. 5. Failing to ensure the facility staff at SNF 1 utilized medical transport when discharging Resident 1 to SNF 2 on [DATE], after the facility identified that Resident 1 was a danger to self and to others. (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:	(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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficient practices resulted in Resident 1 being discharged from SNF 1 to SNF 2 on [DATE] using a non-medical transport after Resident 1 was identified as being a danger to himself (Resident 1) and to others; and placed Resident 1 at increased risk for injury, medication errors, and worsening of unresolved medical conditions. On [DATE] at approximately 3:30 a.m., Resident 1 expired at SNF 2, less than nine hours after arriving at SNF 2. On [DATE] at 5:16 p.m., the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM), Director of Nursing (DON) and Social Service Director (SSD) due to the facility ' s failure to ensure Resident 1 was free from neglect when the facility discharged Resident 1 to SNF 2 without providing safe and orderly discharge. On [DATE] at 3:45 p.m. the ADM provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], Resident 1 was discharged to SNF 2 and is no longer a resident of the facility (SNF 1). 2. On [DATE], the DON in-serviced RN 2 to enter physician orders for discharge only after speaking to the physician. 3. On [DATE], the DON in-serviced the facility Marketer 1 (MTR 1) to no longer arrange resident transportation. 4. On [DATE], the DON in-serviced RN 2 regarding giving report to the nurse at the receiving facility of SNF 2. 5. On [DATE], Medical Director Medical Doctor 1 (MDMD 1) in-serviced the ADM, DON, Assistant Director of Nursing (ADON), SSD, and all other Department Heads regarding ensuring all residents are free of neglect related to discharge services to ensure resident ' s safety and promote their (resident) highest well-being from the time residents enter the facility to the time residents leave the facility. 6. On [DATE], the DON continued providing in-services to admissions office staff, nursing staff, and social services staff regarding the facility ' s current policies and procedures for the prevention of Neglect related to Discharge/Transfer services. On [DATE] at 4:00 p.m. while onsite and after verifying the facility ' s full implementation of the accepted IJ Removal Plan, the SSA removed the IJ situation in the presence of the ADM, DON, and Minimum Data Set Nurse (MDSN). Findings: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- a common lung disease that causes breathing problems by restricting airflow), type two (2) diabetes mellitus (a long-term medical condition in which the body has trouble controlling blood sugar and using it for energy), schizoaffective (a mental illness that can affect a person ' s thoughts, mood and behavior) disorder and psychosis (a severe mental condition in which thought and emotions are affected that contact is lost with external reality). During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], indicated that Resident 1 had memory problems and difficulty in making decisions regarding tasks of daily life. During a review of Resident 1 ' s Admission Summary dated [DATE] timed at 4:00 p.m. indicated Resident 1 was incontinent (unable to voluntarily control the excretion of urine or the contents of the bowels) of bladder (a sac- shaped muscular organ that stores urine) and bowel (a long, tube-shaped organ in the abdomen that is part of the digestive system) function, had unsteady gait (pattern of walking), was confused (refers to the inability to think clearly or quickly), and agitated (a condition in which a person is unable to relax and be still) towards others. The Admission Summary further indicated that Resident 1 had a preference of sitting and crawling on the floor requiring one to one (1:1- where a staff member is assigned to monitor the resident at all times) supervision. During a review of Resident 1 ' s Physician Discharge Summary dated [DATE] indicated Resident 1 ' s discharge was necessary for the health and safety of individuals in the facility that would be endangered due to Resident 1 ' s clinical (medical) or behavioral status. During a review of Resident 1 ' s Notice of Transfer/Discharge, with a notification date of [DATE] and effective date of [DATE], indicated that the notice was to inform Resident1 that the discharge to SNF 2 was necessary for the safety of individuals in the facility that would be endangered due to Resident 1 ' s clinical or behavioral status. During a review of Resident 1`s Physician`s Order dated [DATE], timed at 2:20 p.m., indicated that MD 1 provided a verbal order to discharge Resident 1 to SNF 2. The Physician ' s Order was documented by RN 2 and signed by MD 1. During a review of Resident 1 ' s Recapitulation of Stay dated [DATE], timed at 5:00 p.m. indicated Resident 1 ' s reason for discharge to SNF 2 was because of behavior (not specified). Resident 1 ' s Recapitulation of Stay indicated Resident 1 needed skilled care and nursing services and required assistance with physical functioning such as bathing, bed mobility, dressing, toilet use, locomotion (ability to move from one place to another) and walking. During a review of Resident 1 ' s Health Status Note dated [DATE] timed at 5:10 p.m. indicated Resident 1 was discharged to SNF 2 via a non-medical transport. During a review of Resident 1 ' s SNF 2 Record of Death, dated [DATE], the Record of Death indicated that Resident 1 expired in SNF 2 on [DATE] at 3:30 a.m. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE] at 11:30 a.m. with RN 2, Resident 1 ' s Physician ' s Order dated [DATE], timed at 2:20 p.m. that indicated that MD 1 gave a verbal order to discharge Resident 1 to SNF 2 and was documented by RN 2 was reviewed. RN 2 stated that on [DATE], RN 2 had not spoken with MD 1 to obtain the verbal order for Resident 1 ' s discharge, either in person or by phone before inputting the order to discharge Resident 1 to SNF 2. RN 2 stated that RN 2 entered the physician order to discharged Resident 1 to SNF 2 on [DATE] and indicated that the order was received verbally by MD 1 because RN 2 was told by SSD that Resident 1 needed a physician order for discharge. RN 2 stated that when the SSD informs the licensed nurses of the facility that a resident is to be discharged , a licensed nurse will enter a verbal order for discharged into the resident ' s physician order record on behalf of the physician. During a concurrent interview and record review on [DATE] at 11:50 a.m. with MD 1, MD 1 reviewed Resident 1 ' s Physician ' s Order dated [DATE] to discharge Resident 1 to SNF 2. MD 1 stated that MD 1 was not in the facility on [DATE]. When MD 1 was asked how come MD 1 signed the physician order to discharge Resident 1 to SNF 2 on [DATE] when RN 2 had stated that RN 2 had not spoken with MD 1 to obtain the verbal order for Resident 1 ' s discharge, either in person or by phone, MD 1 stated that this is what is normally done in the facility. MD 1 further stated that Resident 1 ' s physician order to discharge to SNF 2 dated [DATE] did not include the reason for the discharge. During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that only physicians, nurse practitioners and physician assistant can give an order to discharge a resident. RN 2 stated that on [DATE], RN 2 should have, but did not communicate with MD 1 concerning Resident 1 ' s discharge. RN 2 stated that by entering the order to discharge Resident 1 to SNF 2 on [DATE], RN 2 deprived Resident 1 of a safe discharge to SNF 2, which is required for a safe and orderly discharge. During a concurrent interview and record review on [DATE] at 4:07 p.m. with the DON, Resident 1 ' s Physician ' s Order dated [DATE], timed at 2:20 p.m. that indicated that MD 1 gave a verbal order to discharge Resident 1 to SNF 2 and was documented by RN 2 was reviewed. The DON stated that RN 2 ' s actions of entering the order to discharge Resident 1 to SNF 2 on [DATE] without communicating to MD 1 was neglectful and the RN 2 should have acted based on her scope of practice. 2. During an interview with Registered Nurse 4 (RN 4) on [DATE] at 3:12 p.m., RN 4 stated RN 4 worked at SNF 2. RN 4 stated that on [DATE] at approximately 6:40 p.m. Resident 1 arrived at SNF 2 with only a summary of Resident 1 ' s Physician Orders dated [DATE] from SNF 1. RN 4 stated that RN 4 attempted to call SNF 1 several times to attempt to speak with a licensed nurse from SNF 1 and obtain additional discharge information. RN 4 stated SNF 1 did not answer the phone. RN 4 stated that RN 4 had no prior knowledge that Resident 1 would be arriving to be admitted into SNF 2. During an interview with Licensed Vocational Nurse 3 (LVN 3) on [DATE] at 4:15 p.m., LVN 3 stated that LVN 3 works at SNF 2. LVN 3 stated that on [DATE], Resident 1 had suddenly arrived at SNF 2. LVN 3 stated that LVN 3 had no prior knowledge that Resident 1 was arriving to SNF 2 for admission. LVN 3 stated that Resident 1 arrived with no Discharge Summary, and Recapitulation of Stay from SNF 1. LVN 3 stated that Resident 1 arrived with only Resident 1 ' s Physician Order Summary Report (totaling to four pages) from SNF 1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that on [DATE], the only discharge paperwork that RN 2 completed for Resident 1 was writing Resident 1 ' s physician order for discharge. RN 2 stated that RN 2 endorsed Resident 1 ' s discharge to the oncoming shift nurse, Registered Nurse 3 (RN 3). RN 2 stated that RN 3 was to finish Resident 1 ' s discharge on [DATE]. During a concurrent interview and record review on [DATE] at 4:21 p.m. with Medical Records Director 1 (MRD 1), Resident 1 ' s discharge forms, clinical and discharge documentations from [DATE] to [DATE] were reviewed. MRD 1 stated that there was no documented evidence found that a Discharge Care Plan, and a Medication Reconciliation (process of identifying the most accurate list of all medications that the resident is taking) form was completed, and copies of the Discharge Summary and Recapitulation of Stay from SNF 1 were sent with Resident 1 to SNF 2. During an interview with the DON on [DATE] at 4:24 p.m., the DON stated that there was no documented evidence found that copies of Resident 1 ' s Discharge Summary and Recapitulation of Stay from SNF 1 were sent with Resident 1 to SNF 2. The DON stated that this was a neglectful deficient practice because the Discharge Summary and Recapitulation of Stay for Resident 1 should have been provided to Resident 1 as part of the safe and orderly discharge services. During an interview with RN 3 on [DATE] at 5:03 p.m., RN 3 stated that on [DATE] RN 3 completed Resident 1 ' s discharge packet which included Resident 1 ' s Discharge Summary and Recapitulation of Stay. RN 3 stated that RN 3 did not fax the discharge packet of Resident 1 to SNF 2. During a follow-up interview with MRD 1 on [DATE] at 5:58 p.m., MRD 1 stated that the nursing staff involved in Resident 1 ' s discharge on [DATE], that included RN 3, should have but did not send Resident 1 ' s discharge documentation including a Discharge Summary, a Recapitulation of Stay to SNF 2. 3. During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that RN 2 did not, by phone, in person, or in writing, communicate with any staff from SNF 2 of Resident 1 ' s discharge on [DATE]. During an interview with the DON on [DATE] at 4:17 p.m., the DON stated that to the DON ' s best knowledge, no nursing staff from SNF 1 gave a hand off communication report to a licensed nurse at SNF 2 as part of safe and orderly discharge services. The DON stated that this was a neglectful deficient practice because the nursing staff from SNF 1 should have conducted a hand off communication report to the licensed nurses at SNF 2. The DON stated that SNF 2 should be informed of the most current and pertinent nursing and medical information concerning Resident 1 in order to provide the necessary care and services to Resident 1. During an interview with the DON on [DATE] at 4:00 p.m., the DON stated that licensed nurses of SNF 1 did not follow the facility ' s policy and procedure for a safe and orderly discharge, when on [DATE], the facility staff of SNF 1 did not provide a hand off communication regarding Resident 1 ' s pertinent nursing and medical information to SNF 2. During an interview with RN 3 on [DATE] at 5:03 p.m., RN 3 stated that RN 3 did not give a hand off communication report to any staff at SNF 2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with MRD 1 on [DATE] at 5:38 p.m., MRD 1 stated that no nursing staff from SNF 1 documented in Resident 1 ' s medical record that a hand off communication was conducted with SNF 2 regarding Resident 1 ' s discharge on [DATE]. 4. A review of the facility ' s Facility Assessment Data Collection Tool, dated ,d+[DATE] through ,d+[DATE], indicated that the facility had admitted and treated other residents with psychosis and other mental disorders, impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), dementia (the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life). The facility ' s Facility Assessment Data Collection Tool further indicated that the facility had admitted and treated residents in need of behavioral support, behavioral healthcare needs dementia care .and other mental disorders. During a concurrent interview and record review on [DATE] at 3:20 p.m. with the DON, the facility ' s Facility Assessment Data Collection Tool dated ,d+[DATE] through ,d+[DATE] was reviewed. The DON stated that the facility was capable of and had been providing care for residents with same diagnoses and behavior that Resident 1 had. The DON stated she was not aware of any services that Resident 1 needed that the facility could not provide that SNF 2 could provide other than that SNF 2 was not a locked facility. During a review of Resident 1 ' s Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their residents) Conference Notes, dated [DATE], indicated the facility ' s IDT met to discuss Resident 1 ' s condition as of [DATE], two days after the facility admitted Resident 1 from General Acute Care Hospital 2 (GACH 2) on [DATE]. The document indicated the IDT specifically discussed Resident 1 ' s fall incidents, Resident 1 ' s nutritional status and weight, Resident 1 ' s need for reminders to participate in group activities and a one to one staff assignment to ensure resident is safe. The document also indicated, Unable to determine discharge plan at this time. During a review of Resident 1 ' s Health Status Note, dated [DATE], 2:43 p.m., the health status note indicated that Resident 1 was unsteady on his feet and needed a one-to-one supervision (a nurse or health care support worker who provides care to a single resident for a period of time) to ensure his (Resident 1) safety related to falls prevention. During a review of Resident 1 ' s care plan dated [DATE] indicated that Resident 1 was at risk for wandering (a resident ' s aimless, repetitive movement from one area to another that puts them at risk of harm). During an interview with MTR 1 on [DATE] at 11:32 a.m., MTR 1 stated that MTR 1 did not know the specific reason why the facility wanted to discharge Resident 1 to SNF 2 or what services Resident 1 needed that SNF 1 could not provide but SNF 2 could. During an interview with the DON on [DATE] at 3:29 p.m., the DON stated that Resident 1 had medical conditions and needs such that Resident 1 required the level of care that a locked unit can provide. The DON stated specifically, Resident 1 needed one-to-one supervision to prevent falls. The DON further stated that Resident 1 was at risk for elopement (to leave a skilled nursing facility without notice or permission), from the facility related to Resident 1 ' s wandering behavior. The DON stated that there was nothing required in Resident 1 ' s plan of care that SNF 1 could not provide. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE] at 3:35 p.m. with the DON, reviewed Resident 1 ' s IDT Conference Note dated [DATE]. The DON stated that on [DATE], the IDT Team was unable to determine discharge plans for Resident 1. The DON stated that Resident 1 required one-to-one supervision to ensure Resident 1 ' s safety. The DON stated that Resident 1 had episodes of aggressive behaviors towards staff however the IDT Conference Note dated [DATE] did not indicate what specific behaviors were observed, what specific interventions could have been implemented to address the aggressive behaviors or other behaviors related to Resident 1 ' s mental illness. The DON stated there was no documentation found of the facility ' s attempts to meet the resident ' s needs or what services the new receiving facility (SNF 2) had in order to meet the resident ' s needs. During an interview with the ADM on [DATE], 3:59 p.m., ADM stated that ADM was not aware of any specific services that Resident 1 needed that SNF 1 could not provide but that SNF 2 could provide. 5. During an interview with RN 4 on [DATE] at 3:12 p.m., RN 4 stated RN 4 worked at SNF 2. RN 4 stated that on [DATE], at approximately 6:40 p.m. the driver (Driver 1) of a private non-medical vehicle arrived at SNF 2 and informed RN 4 that he (Driver 1) was instructed to drop off Resident 1. RN 4 stated that Driver 1 helped bring Resident 1 inside SNF 2. During an interview with the DON on [DATE] at 4:26 p.m., the DON stated that the facility did not ensure that Resident 1 was provided with a safe and appropriate (medical) form of transportation when the facility utilized a ride share company (a company that uses independent contractors with no training regarding medical safety, to transport people between various places) to discharge Resident 1 to SNF 2. The DON stated that SNF 1 had knowledge of Resident 1 ' s medical condition and history of aggressive behavior. The DON stated that Resident 1 ' s medical conditions included mental illness, and therefore the facility should have provided Resident 1 with professional medical transportation services to ensure Resident 1 ' s safety as part of safe and orderly discharge services. The DON stated that utilizing a non-medical transportation to transport Resident 1 from SNF 1 to SNF 2 was neglectful because the facility should have provided Resident 1 with professional medical transportation services as part of safe and orderly discharge services but did not do so. During a concurrent interview and record review on [DATE] at 3:40 p.m., with the DON, the facility ' s policy titled, Resident Rights, last reviewed by the facility on [DATE], was reviewed. The policy indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to . to be free from . neglect . The DON stated that Resident 1 had a right to safe and orderly discharge services as defined by federal regulations and the facilities policies regarding discharge services. The DON stated that the facility did not follow its policy regarding resident ' s right to be free of neglect when the facility failed to provide Resident 1 with safe and orderly discharge services on [DATE].

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40537 Based on interview and record review, the facility (Skilled Nursing Facility 1 [SNF 1]) failed to ensure a safe and orderly discharge was provided to one of three sampled residents (Resident 1), who exhibited behaviors that made Resident 1 a danger to himself (Resident 1) and others, and who was admitted to SNF 1, a locked facility (facility that cares for residents that utilize secured perimeter fences or locked exit doors) to Skilled Nursing Facility 2 (SNF 2), a non-locked facility (a facility that does not have secured or locked units) on [DATE] by: 1. Failing to ensure Registered Nurse 2 (RN 2) obtained a physician order from Medical Doctor 1 (MD 1-Resident 1 ' s attending physician) to discharge Resident 1 to SNF 2 on [DATE]. 2. Failing to ensure that the facility staff at SNF 1 provided SNF 2 with the discharge summary and recapitulation of stay (a summary of a resident course of treatment and stay at a facility) for Resident 1 when Resident 1 was discharged to SNF 2 on [DATE]. SNF 2 was only provided the Order Summary Report (a list of the physician orders for a resident, while the resident was admitted to a facility). 3. Failing to ensure facility staff from SNF 1 conducted a hand off communication (the transfer of resident medical information from the licensed nurse of the discharging facility to the licensed nurse of the receiving facility for continuity of care) to SNF 2 in preparation of receiving and admitting Resident 1 on [DATE]. 4. Failing to ensure facility staff established or specified the specific care that Resident 1 needed that SNF 1, a locked unit was unable to provide, that required Resident 1 to be discharged to SNF 2, an unlocked and less secure unit. 5. Failing to ensure the facility staff at SNF 1 utilized medical transport when discharging Resident 1 to SNF 2 on [DATE], after the facility identified that Resident 1 was a danger to self and to others. These deficient practices resulted in Resident 1 being discharged from SNF 1 to SNF 2 on [DATE] using a non-medical transport after Resident 1 was identified as being a danger to himself (Resident 1) and to others; and placed Resident 1 at increased risk for injury, medication errors, and worsening of unresolved medical conditions. On [DATE] at approximately 3:30 a.m., Resident 1 expired at SNF 2, less than nine hours after arriving at SNF 2. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:16 p.m., the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM), Director of Nursing (DON) and Social Service Director (SSD) due to the facility ' s failure to ensure Resident 1 was provided a safe and orderly discharge when the facility discharged Resident 1 to SNF 2 using a non-medical transport, and without conducting a hand off communication to ensure continuity of care in order to minimize the risk of medical errors, and ensure all necessary medical information of Resident 1 from SNF 1 was given to SNF 2 in order to allow for a seamless transition of care upon discharge. On [DATE] at 3:45 p.m. the ADM provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], Resident 1 was discharged to SNF 2 and is no longer a resident of the facility (SNF 1). 2. On [DATE], the DON in-serviced RN 2 to enter physician orders for discharge only after speaking to the physician. 3. On [DATE], the DON in-serviced the facility Marketer 1 (MTR 1) to no longer arrange resident transportation. 4. On [DATE], the DON in-serviced RN 2 regarding giving report to the nurse at the receiving facility of SNF 2. 5. On [DATE], Medical Director Medical Doctor 1 (MDMD 1) in-serviced the ADM, DON, Assistant Director of Nursing (ADON), SSD, regarding ensuring all residents receive all discharge services (providing and completed needed discharge documentations and conducting hand off report to receiving facility) needed to ensure the resident ' s safety and promote the resident ' s highest well being from the time of discharge. On [DATE] at 4:00 p.m. while onsite and after verifying the facility ' s full implementation of the accepted IJ Removal Plan, the SSA removed the IJ situation in the presence of the ADM, DON, and Minimum Data Set Nurse (MDSN). Findings: 1. During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- a common lung disease that causes breathing problems by restricting airflow), type two (2) diabetes mellitus (a long-term medical condition in which the body has trouble controlling blood sugar and using it for energy), schizoaffective (a mental illness that can affect a person ' s thoughts, mood and behavior) disorder and psychosis (a severe mental condition in which thought and emotions are affected that contact is lost with external reality). During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], indicated that Resident 1 had memory problems and difficulty in making decisions regarding tasks of daily life. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Admission Summary dated [DATE] timed at 4:00 p.m. indicated Resident 1 was incontinent (unable to voluntarily control the excretion of urine or the contents of the bowels) of bladder and bowel function, had unsteady gait (pattern of walking), has confusion (refers to the inability to think clearly or quickly), and agitated (a condition in which a person is unable to relax and be still) towards others. The Admission Summary further indicated that Resident 1 has a preference of sitting and crawling on the floor requiring one to one (1:1- where a staff member is assigned to monitor the resident at all times) supervision. During a review of Resident 1 ' s Physician Discharge Summary dated [DATE] indicated Resident 1 ' s discharge was necessary for the health and safety of individuals in the facility that would be endangered due to Resident 1 ' s clinical (medical) or behavioral status. During a review of Resident 1 ' s Notice of Transfer/Discharge, with a notification date of [DATE] and effective date of [DATE], indicated that the notice was to inform Resident1 that the discharge to SNF 2 was necessary for the safety of individuals in the facility that would be endangered due to Resident 1 ' s clinical or behavioral status. During a review of Resident 1`s Physician`s Orders dated [DATE], timed at 2:20 p.m., indicated that MD 1 provided a verbal order to discharge Resident 1 to SNF 2. The order was documented by RN 2 and signed by MD 1. During a review of Resident 1 ' s Recapitulation of Stay dated [DATE], timed at 5:00 p.m. indicated Resident 1 ' s reason for discharge to SNF 2 was because of behavior (not specified). Resident 1 ' s Recapitulation of Stay indicated Resident 1 needed skilled care and nursing services and required assistance with physical functioning such as bathing, bed mobility, dressing, toilet use, locomotion (ability to move from one place to another) and walking. During a review of Resident 1 ' s Health Status Note dated [DATE] timed at 5:10 p.m. indicated Resident 1 was discharged to SNF 2 via a non-medical transport. During a review of Resident 1 ' s SNF 2 Record of Death, dated [DATE], the Record of Death indicated that Resident 1 expired in SNF 2 on [DATE] at 3:30 a.m. During a concurrent interview and record review on [DATE] at 11:30 a.m. with RN 2, Resident 1 ' s Physician ' s Order dated [DATE], timed at 2:20 p.m. that indicated that MD 1 gave a verbal order to discharge Resident 1 to SNF 2 and was documented by RN 2 was reviewed. RN 2 stated that on [DATE], RN 2 had not spoken with MD 1 to obtain the verbal order for Resident 1 ' s discharge, either in person or by phone before inputting the order to discharge Resident 1 to SNF 2. RN 2 stated that RN 2 entered the physician order to discharged Resident 1 to SNF 2 on [DATE] and indicated that the order was received verbally by MD 1 because RN 2 was told by SSD that Resident 1 needed a physician order for discharge. RN 2 stated that when the SSD informs the licensed nurses of the facility that a resident is to be discharged , a licensed nurse will enter a verbal order for discharged into the resident ' s physician order record on behalf of the physician. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE] at 11:50 a.m. with MD 1, MD 1 reviewed Resident 1 ' s Physician ' s Order dated [DATE] to discharge Resident 1 to SNF 2. MD 1 stated that MD 1 was not in the facility on [DATE]. When MD 1 was asked how come MD 1 signed the physician order to discharge Resident 1 to SNF 2 on [DATE] when RN 2 had stated that RN 2 had not spoken with MD 1 to obtain the verbal order for Resident 1 ' s discharge, either in person or by phone, MD 1 stated that this is what is normally done in the facility. MD 1 further stated that Resident 1 ' s physician order to discharge to SNF 2 dated [DATE] did not include the reason for the discharge. During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that only physicians, nurse practitioners and physician assistant can give an order to discharge a resident. RN 2 stated that on [DATE], RN 2 should have, but did not communicate with MD 1 concerning Resident 1 ' s discharge. RN 2 stated that by entering the order to discharge Resident 1 to SNF 2 on [DATE], RN 2 deprived Resident 1 of a safe discharge to SNF 2, which is required for a safe and orderly discharge. 2. During an interview with Registered Nurse 4 (RN 4) on [DATE] at 3:12 p.m., RN 4 stated RN 4 worked at SNF 2. RN 4 stated that on [DATE] at approximately 6:40 p.m. Resident 1 arrived at SNF 2 with only a summary of Resident 1 ' s Physician Orders dated [DATE] from SNF 1. RN 4 stated that RN 4 attempted to call SNF 1 several times to attempt to speak with a licensed nurse from SNF 1 and obtain additional discharge information. RN 4 stated SNF 1 did not answer the phone. RN 4 stated that RN 4 had no prior knowledge that Resident 1 would be arriving to be admitted into SNF 2. During an interview with Licensed Vocational Nurse 3 (LVN 3) on [DATE] at 4:15 p.m., LVN 3 stated that LVN 3 works at SNF 2. LVN 3 stated that on [DATE], Resident 1 had suddenly arrived at SNF 2. LVN 3 stated that LVN 3 had no prior knowledge that Resident 1 was arriving to SNF 2 for admission. LVN 3 stated that Resident 1 arrived with no discharge summary, and recapitulation of stay from SNF 1. LVN 3 stated that Resident 1 arrived with only Resident 1 ' s Physician Order Summary Report (totaling to four pages) from SNF 1. During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that on [DATE], the only discharge paperwork that RN 2 completed for Resident 1 was writing Resident 1 ' s physician order for discharge. RN 2 stated that RN 2 endorsed Resident 1 ' s discharge to the oncoming shift nurse, Registered Nurse 3 (RN 3). RN 2 stated that RN 3 was to finish Resident 1 ' s discharge on [DATE]. During an interview with RN 3 on [DATE] at 5:03 p.m., RN 3 stated that on [DATE] RN 3 completed Resident 1 ' s discharge packet which included Resident 1 ' s Discharge Summary and Recapitulation of Stay. RN 3 stated that RN 3 did not fax the discharge packet of Resident 1 to SNF 2. During an interview with Medical Records Director 1 (MRD 1) on [DATE] at 5:58 p.m., MRD 1 stated that the nursing staff involved in Resident 1 ' s discharge on [DATE], that included RN 3, should have but did not send Resident 1 ' s discharge documentation including a Discharge Summary, a Recapitulation of Stay to SNF 2. 3. During an interview with RN 2 on [DATE] at 4:02 p.m., RN 2 stated that RN 2 did not, by phone, in person, or in writing, communicate with any staff from SNF 2 of Resident 1 ' s discharge on [DATE]. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 4:17 p.m., the DON stated that to the DON ' s best knowledge, no nursing staff from SNF 1 gave a hand off communication report to a licensed nurse at SNF 2 as part of safe and orderly discharge services. DON stated that since the nursing staff from SNF 1 did not give a hand off communication report to the licensed nurses at SNF 2, SNF 2 would not know the most current and pertinent nursing and medical information concerning Resident 1. During an interview with the DON on [DATE] at 4:00 p.m., the DON stated that licensed nurses of SNF 1 did not follow the facility ' s policy and procedure for a safe and orderly discharge, when on [DATE], the facility staff of SNF 1 did not provide a hand off communication regarding Resident 1 ' s pertinent nursing and medical information to SNF 2. During an interview with RN 3 on [DATE] at 5:03 p.m., RN 3 stated that RN 3 did not give a hand off communication report to any staff at SNF 2. During an interview with MRD 1 on [DATE] at 5:38 p.m., MRD 1 stated that no nursing staff from SNF 1 documented in Resident 1 ' s medical record that a hand off communication was conducted with SNF 2 regarding Resident 1 ' s discharge on [DATE]. 4. During a review of Resident 1 ' s Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their residents) Conference Notes, dated [DATE], indicated the facility ' s IDT met to discuss Resident 1 ' s condition as of [DATE], two days after the facility admitted Resident 1 from General Acute Care Hospital 2 (GACH 2) on [DATE]. The document indicated the IDT specifically discussed Resident 1 ' s fall incidents, Resident 1 ' s nutritional status and weight, Resident 1 ' s need for reminders to participate in group activities and a one to one staff assignment to ensure resident is safe. The document also indicated, Unable to determine discharge plan at this time. During a review of Resident 1 ' s Health Status Note, dated [DATE], 2:43 p.m., the health status note indicated that Resident 1 was unsteady on his feet and needed a one-to-one supervision (a nurse or health care support worker who provides care to a single resident for a period of time) to ensure his (Resident 1) safety related to falls prevention. During a review of Resident 1 ' s care plan dated [DATE] indicated that Resident 1 was at risk for wandering (a resident ' s aimless, repetitive movement from one area to another that puts them at risk of harm). During an interview with MTR 1 on [DATE] at 11:32 a.m., MTR 1 stated that MTR 1 did not know the specific reason why the facility wanted to discharge Resident 1 to SNF 2 or what services Resident 1 needed that SNF 1 could not provide but SNF 2 could. During an interview with the DON on [DATE] at 3:29 p.m., the DON stated that Resident 1 had medical conditions and needs such that Resident 1 required the level of care that a locked unit can provide. The DON stated specifically, Resident 1 needed one-to-one supervision to prevent falls. The DON further stated that Resident 1 was at risk for elopement (to leave a skilled nursing facility without notice or permission), from the facility related to Resident 1 ' s wandering behavior. The DON stated that there was nothing required in Resident 1 ' s plan of care that SNF 1 could not provide. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE] at 3:35 p.m. with the DON, reviewed Resident 1 ' s IDT Conference Note dated [DATE]. The DON stated that on [DATE], the IDT Team was unable to determine discharge plans for Resident 1. The DON stated that Resident 1 required one-to-one supervision to ensure Resident 1 ' s safety. The DON stated that Resident 1 had episodes of aggressive behaviors towards staff however the IDT Conference Note dated [DATE] did not indicate what specific behaviors were observed, what specific interventions could have been implemented to address the aggressive behaviors or other behaviors related to Resident 1 ' s mental illness. The DON stated there was no documentation found of the facility ' s attempts to meet the resident ' s needs or what services the new receiving facility (SNF 2) had in order to meet the resident ' s needs. During an interview with the ADM on [DATE], 3:59 p.m., ADM stated that ADM 1 was not aware of any specific services that Resident 1 needed that SNF 1 could not provide but that SNF 2 could provide. 5. During an interview with RN 4 on [DATE] at 3:12 p.m., RN 4 stated RN 4 worked at SNF 2. RN 4 stated that on [DATE], at approximately 6:40 p.m. the driver (Driver 1) of a private non-medical vehicle arrived at SNF 2 and informed RN 4 that he (Driver 1) was instructed to drop off Resident 1. RN 4 stated that Driver 1 helped bring Resident 1 inside SNF 2. During an interview with the DON on [DATE] at 4:26 p.m., the DON stated that the facility did not ensure that Resident 1 was provided with a safe and appropriate form of transportation when the facility utilized a ride share company (a company that uses independent contractors with no training regarding medical safety, to transport people between various places) to discharge Resident 1 to SNF 2. The DON stated that SNF 1 had knowledge of Resident 1 ' s medical condition and history of aggressive behavior. The DON stated that Resident 1 ' s medical conditions included mental illness, and therefore the facility should have provided Resident 1 with professional medical transportation services to ensure Resident 1 ' s safety as part of safe and orderly discharge services. During a review of the facility ' s policy and procedure titled Discharging the Resident, last reviewed [DATE], indicated that if a resident is being discharged to another facility, the facility is to ensure a transfer summary is completed and telephone report is called to the receiving facility. During a review of the facility ' s policy and procedure titled Transfer of Discharge Documentation, last reviewed on [DATE], indicated that documentation from the Care Planning Team concerning all transfers or discharges must include, as a minimum a. The reason(s) for the transfer or discharge f. A summary of the resident's overall medical, physical, and mental condition h. Disposition of medications . Should the resident be transferred or discharged for the following reasons, the basis for the transfer or discharge must be documented in the resident's clinical record by the resident's Attending Physician: (continued on next page)

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