STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555785	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Care Center	1880 Dawson Avenue Signal Hill, CA 90806

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** 45537 Based on interview and record review, the facility failed to ensure a resident, who was assessed to have a cognitive (the mental process of thinking, learning, remembering, being aware of surroundings and using judgement) impairment and the inability to make medical decisions, was not allowed to leave from the facility against medical advice ([AMA] when a patient chooses to leave a hospital before the doctor recommends discharge) and they failed to ensure discharge planning was conducted for one of three sampled residents (Resident 1) when the facility was made aware that Resident 1's significant other had intentions of taking Resident 1 from the facility AMA. The facility failed to: 1. Ensure a plan for Resident 1's safe discharge was developed when the facility was made aware of Resident 1's significant other's desire to leave the facility, five days before Resident 1's significant other took Resident 1 from the facility without the facility's knowledge or permission. 2. Ensure Resident 1 was not taken from the facility by an unauthorized person (significant other) without the facility's knowledge or permission, resulting in Resident 1's whereabouts being unknown for two days, and upon location of Resident 1 at a homeless encampment, Resident 1 and the significant other were asked to discharge from the facility by signing an AMA form. 3. Ensure Resident 1 was assessed by facility staff, documenting Resident 1's medical condition when he was located at a homeless encampment two days after being taken from the facility, then asking Resident 1 and the significant other to sign the facility's AMA form, without prior discharge planning to ensure Resident 1 was safe and care was provided. 4. Ensure emergency medical services (911) were called to assess Resident 1's medical status and determine if Resident 1 required transport to a General Acute Care Hospital (GACH) for evaluation and treatment as needed instead they asked Resident 1 and the significant other to sign the facility's AMA form, discharging the from the facility without prior discharge planning to ensure Resident 1 was safely discharged . 5. Ensure Resident 1 and/or the significant other, who took him from the facility without the facility's knowledge or permission, was able provide care for Resident 1 before they (Resident 1 and the significant other) were asked to sign AMA discharge documents. (continued on next page)

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 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficient practices resulted in Resident 1, who was incontinent (involuntary voiding of urine and stool), non-ambulatory (inability to walk) with medical conditions/diagnoses that required medication, and whose cognition was severely impaired, being removed from the facility by an unauthorized person without the facility's knowledge or permission. Resident 1's whereabouts were unknown to the facility for two days before he was found residing in a homeless encampment approximately two miles from the facility. Resident 1 was found lying on the floor in a dark tent on a thin mattress and was subjected to poor weather conditions, unsanitary environmental conditions, he was without medication, discharge instructions, caregiver training or provisions necessary to properly care for himself. These deficient practices placed Resident 1 at risk for deterioration of his medical condition, and death. On 12/11/2024 at 3:35 p.m. 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) was called in the presence of the facility's Administrator (ADM) and Director of Nursing (DON) due to the facility's failures identify Resident 1's Responsible Party (RP), develop a safe discharge plan to facilitate Resident 1's discharge, and failure to ensure Resident 1's physical and mental status was assessed to determine his need for hospitalization following Resident 1's unknown whereabouts for two day. On 12/13/2024, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 12/13/2024 at 5 p.m. in the presence of the facility's ADM, DON, and Director of Staff Development (DSD). The facility's IJPR included the following immediate actions: 1. Facility staff went to a homeless encampment at a park, located two miles from the facility, on 12/11/2024, at approximately 5 p.m. The Resident (Resident 1) and his tent were no longer at the same location. On 12/12/2024, at approximately 8:15 a.m., the DON drove by the local area park again where Resident 1 and his Responsible Party (significant other) were found. The DON confirmed that this was Resident 1. Resident 1 was not in any distress and had no signs of diminished cognitive response. Resident 1 was sitting in a wheelchair, his breathing was even and unlabored, he was asked his full name and date of birth, and he was able to respond appropriately. The DON called 911 and the paramedics arrived while the DON remained at the park. The paramedics asked Resident 1 if they could assess him, and he refused. The paramedics offered to take the Resident 1 to the hospital, he and the significant other refused. The paramedics informed the ADM and the DON that they could not force Resident 1 to go to the hospital against and they (Resident 1 and the significant other) had a right to refuse. Resident 1 refused transport with the paramedics and refused an offer to return to the facility. The facility offered Resident 1 and the significant other supplies, but Resident 1 and the significant other told facility representatives to stop bothering them. The DON attempted to notify the Resident 1's Physician at 10:30 a.m., and 3:30 p.m., on 12/12/2024. The Physician called back at 5:45 p. m., he was notified that Resident 1 refused to come back to the facility or go to the hospital to be evaluated. The Physician stated, Well, there is nothing we can do. They have the right to refuse. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The facility reviewed Resident 1's medical records, which were available during Resident 1's admission and confirmed the significant other was listed as his Responsible Party in his previous hospital records and his facility history and physical (H&P). The facility also confirmed that Resident 1 and the significant other once resided at the same address. The significant other refused to provide any identifying information to the paramedics or facility representatives on 12/12/2024, because the significant other said that information was personal. The significant other introduced herself to the paramedics as Resident 1's wife and caretaker. 3. On 12/12/2024 the facility Social Services Director (SSD), DON and Minimum Data Set ([MDS] resident assessment tool) nurse reviewed documents for all residents discharged in the past months from 11/12/2024 to 12/12/0224 (12 records), no deficient practices were identified. No other residents left the facility AMA in the past 3 months. 4. On 12/12/2024 the Continuous Quality Improvement (CQI) Nurse Consultant in-serviced all licensed nurses who were present and the Interdisciplinary Team ([IDT] a collaborative group composed of professionals from different disciplines who work together to achieve a common goal) on the facility's policy and procedure pertaining to the discharge process, discharge planning, AMA, and care for residents with cognitive impairment and physical limitations. In-services were done with licensed nurses who were present on 12/11/2024, 12/12/2024 and 12/13/2024 on all shifts. Staff who were not present for the in-services will be in-serviced via phone and will be asked to sign the in-service form upon return to the facility. If unable to in-service via phone, staff will be in-serviced upon returning to work. Staff will not be returned to the floor until in-serviced. 5. On 12/12/2024, the DON and CQI Nurse Consultant reviewed all current residents' records (53) for presence of information about the responsible party, including contact information and followed up to request information for any residents missing this information. No discrepancies were found. 6. The facility will initiate discharge planning with the resident or resident's representative if the resident has no capacity to make decisions during initial social service assessment and discuss the discharge process and plan during the initial IDT care conference within one week of admission if the resident or representative agree and are available. 7. When a resident or resident's representative expresses the desire to leave the facility, the social service will call for a discharge plan meeting to discuss the resident's post discharge needs unless the plan is already in place. If a resident or representative expresses the desire or intention to leave facility AMA and the physician determines the resident is not ready for discharge and will not issue a discharge order, the facility will present the resident or the representative with information regarding the risks and the consequences of leaving and request that they sign an AMA form. The Physician will be notified regarding the AMA. 8. In the event that a resident leaves the facility without notice, the facility staff will assess the resident for any signs of injury or change of condition once located. The facility may transfer the resident to the emergency department (ED) for further evaluation if needed and the resident will be returned to the facility if the resident or the representative agrees. The facility will involve emergency services personnel as necessary. Findings: (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition that causes confusion, memory loss and loss of consciousness), status post (after or following) a stroke with right side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a slight paralysis or weakness on one side of the body), functional quadriplegia (the lack of ability to use one's limbs or to ambulate due to extreme debility or frailty caused by another medical condition without physical injury or damage to the spinal cord), hypertension ([HTN] high blood pressure [BP]), dysarthria (speech that is slurred slow and difficult to understand), benign prostatic hypertrophy ([BPH] a condition in which the prostate is enlarged causing slow urine flow or blockage of urine from the bladder), a urinary tract infection ([UTI] an infection that affects all or part of the urinary tract including the bladder and kidneys), hypothyroidism (a condition when there is not enough hormones in the body to control the body's use of energy), generalized weakness and a history of repeated falls. The Face Sheet indicated there was no responsible person listed only a contact person (the significant other). The contact person listed had no documented contact information, such as address or telephone number. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was not able to make decisions for himself, was incontinent of bladder and bowel functions, was non ambulatory, and was totally dependent on two or more staff to complete his activities of daily living ([ADLS] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's H&P dated 11/23/2024, the H&P indicated Resident 1 was able to make his needs known but could not make medical decisions. During a review of Resident 1's Physician's Order, dated 11/22/2024, the Physician's Order indicated Resident 1 was incapable of giving informed consent (a process where a patient is given clear and comprehensive information about a particular action, procedure, or situation, to ensure they understand the risks, benefits, alternatives, and potential consequences of medical interventions) and he was unable to participate in his plan of care. During a review of Resident 1's Physician's Order, dated 11/22/2024 the Physician's Order indicated the following medications were prescribed to Resident 1: 1. Norvasc (a medication used to treat high blood pressure) 2.5 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) one tablet daily for HTN hold for systolic BP (the top number in a BP reading) of less than 100. 2. Doxazosin Mesylate (a medication used to treat urinary problems caused by an enlarged prostate, which includes difficulty urinating) 2.0 mg one tablet daily for BPH. 3. Lipitor (a medication that lowers cholesterol) 20 mg 1 tablet by mouth at bedtime for hyperlipidemia (abnormally elevated levels of any or all lipids [fats] in the blood). 4. Hydrocodone Acetaminophen (a pain medication) 5/325 mg one tablet every four hours as needed for moderate to severe pain (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Social Service Note dated 12/2/2024 and timed at 5:48 p.m., the Social Service Note indicated Resident 1 and the significant other was located at a homeless encampment, paramedics were called for a wellness check but only a police officer arrived. The Social Service Note indicated Resident 1's significant other stated to the police officer, in the presence of the SSD, that Resident 1 would be okay with her because she had a hex on Resident 1. The Social Service Note indicated Resident 1 was able to state his name and birthdate and that he wanted to stay with the significant other, they (Resident 1 and the significant other) signed the facility's AMA form. During an interview on 12/4/2024 at 11 a.m., Resident 2 stated he was Resident 1's roommate and Resident 1 was not able to express himself and would only mumble. Resident 2 stated Resident 1 had a female visitor, referring to the significant other, that would visit him every other day. Resident 2 stated, on a Saturday afternoon (11/30/2024) he overheard the female visitor telling Resident 1 they were going for a walk, and they left the room with the female visitor pushing Resident 1 in a wheelchair. During an interview on 12/4/2024 at 5:21 p.m., the SSD stated the DON and other licensed nurses were aware (11/25/2024) that Resident 1's significant other voiced her intention of taking Resident 1 out of the facility AMA. The SSD stated on 11/30/2024 the significant other took Resident 1 out of the facility without staff knowledge or permission. The SSD stated on 12/2/2024 (two days after Resident 1 was taken from the facility) after 3 p.m., Resident 1 was found in a homeless encampment with the significant other, two miles away from the facility, they were living in a dark tent, and Resident 1 was lying on a thin mattress on the ground. The SSD stated she called the paramedics, but a police officer showed up. The SSD stated the police officer spoke to Resident 1 and determined Resident 1 was in no distress because he (Resident 1) knew his name, his date of birth and voiced he (Resident 1) wanted to stay at the homeless encampment with the significant other. The SSD stated Resident 1's significant other when questioned, stated not to worry about Resident 1 because she had a hex on him, and he would be okay. The SSD stated the DON had Resident 1 and the significant other signed the facility's AMA form. The SSD stated Resident 1's discharge was unsafe, and it was not the discharge process that the facility encouraged. The SSD acknowledged that Resident 1's significant other took the risk and put Resident 1 in a dangerous situation. During an interview on 12/4/2024 at 6:05 p.m., and a subsequent interview on 12/10/2024 at 2:30 p.m., the DON stated she and other members of the facility were aware of Resident 1's significant other's intention to take Resident 1 out of the facility AMA. The DON stated they did not notify Resident 1's physician of the requested AMA and there was no change of condition (COC), or care plan created to address the significant other's intention. The DON stated Resident 1's physician should have been notified of Resident 1's and/or the significant other's intention to leave the facility AMA so the physician could have had an opportunity to speak to Resident 1 and the significant other about the risks of leaving the facility AMA. The DON stated the goal of the facility was to discharge the residents properly to prevent any decline in health or other complications, but the decision was made to allow Resident 1 and the significant other to sign the AMA form because they could not force Resident 1 to come back to the facility. The DON stated she understood it was an unsafe discharge, but she felt the facility did everything they could for Resident 1. The DON acknowledged she did not assess Resident 1's health status when they found him at the homeless encampment after he was missing from the facility for two days, prior to allowing Resident 1 and the significant other to sign the AMA form, nor did they call the paramedics to transport Resident 1 to the GACH for an in-depth medical evaluation, but she could not answer why this was not done. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/9/2024 at 11:50 a.m., Certified Occupational Therapy Assistant (COTA 1) stated Resident 1 would only respond yes or no to questions, he needed a lot of cueing to stay on task and required maximal assist to complete his ADLs. COTA 1 stated Resident 1 and the significant other should have been trained prior to discharge from the facility to ensure Resident 1 would be assisted at home in a safe and effective manner. During an interview on 12/9/2024 at 2:06 p.m., and a subsequent interview on 12/10/2024 at 3:05 p.m., the ADM stated Resident 1 and the significant other were allowed to sign the AMA form because Resident 1 was able to state his name and birthdate three times and the significant other was Resident 1's family member. The ADM stated she and the other facility staff did not call the paramedics when they found Resident 1 at the homeless encampment because the police officer did not find Resident 1 to be in distress. The ADM stated she determined Resident 1 was not in distress based on his appearance and from the wellness check that the police officer did. During an interview on 12/10/2024 at 1:30 p.m., the Minimum Data Set Nurse (MDSN) stated she and the other members of the facility together with a police officer found Resident 1 at a homeless encampment with the significant other. The MDSN stated Resident 1 was living inside of a dark tent, lying on top of a thin mattress on the ground, there was no electricity, no water supply, and no means to dispose of their waste. The MDSN stated she and the DON did not assess Resident 1's health condition when they found him, nor did they call the paramedics to assess Resident 1's overall health condition. The MDSN stated they should have called 911 to ensure Resident 1 was taken to a GACH for evaluation and treatment as needed. During a telephone interview on 12/12/2024 at 6:09 p.m., Resident 1's Physician stated Resident 1 had no capacity to give consent, he was not able to participate in his plan of care, and he had no capacity to make medical decisions. The Physician stated, although he was not sure if Resident 1's significant other had a sound mind and mental capacity to make decisions or care for Resident 1, she was the person who visited Resident 1 at the GACH, and the facility assumed she was Resident 1's RP. The Physician stated Resident 1's discharge AMA was unsafe because Resident 1 was not properly prepared to transition to the community and he was living in a dire (a situation or event that causse great fear and worry) situation with no proper assistance with his ADLs, no medication, no electricity, unsafe/unsanitary living conditions and exposure to poor weather conditions. During a review of the facility's P/P titled Leaving Against Medical Advice/Without a Discharge Order/Elopement revised 3/25/2023 the P/P indicated the resident who can make their own decisions, has the right to decide whether or not to submit to medical treatment and rehabilitation services and if the resident wants to leave the facility and the physician concurs, the resident may be discharged and if the resident who can make their own decisions decides to leave the facility against the recommendation of the physician, the resident may sign out AMA. The P/P indicated residents who cannot make their own decisions, the conservator and/or the resident's representative will be contacted if she/he wishes to leave the facility and the resident's representative and/or conservator will be informed of the risks related to discharge. The P/P indicated, the resident's representative may make the decision on behalf of the resident and if the facility has concerns regarding the release of the resident, the facility's recourse is through the courts. The P/P indicated the physician or designee will attempt to provide the resident information regarding potential consequences of the action of risk of leaving and the benefits of staying in the facility, and any alternatives. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's P/P, titled Discharging the Resident revised 11/2023 indicated the facility must follow the guidelines of discharge process as follows: 1. Documentation of where the new location is 2. Determine who will provide for the resident's care and if the resident is discharged home, ensure the resident and/or responsible party receive teaching and discharge instructions, and 3. Conduct an assessment of the resident condition at discharge, including skin assessment and documentation

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure a resident, who was assessed to have a cognitive (the mental process of thinking, learning, remembering, being aware of surroundings and using judgement) impairment and the inability to make medical decisions, was not taken out of the facility by a person who was listed in his clinical record as his contact and who had no contact information such as an address or telephone number listed. These deficient practices resulted in Resident 1, who was incontinent (involuntary voiding of urine and stool), non-ambulatory (inability to walk) with medical conditions/diagnoses that required medication, and whose cognition was severely impaired, being removed from the facility by an unauthorized person without the facility's knowledge or permission. Resident 1's whereabouts were unknown to the facility for two days before he was found residing in a homeless encampment approximately two miles from the facility. Resident 1 was found lying on the floor in a dark tent on a thin mattress and was subjected to poor weather conditions, unsanitary environmental conditions, he was without medication, discharge instructions, caregiver training or provisions necessary to properly care for himself. These deficient practices placed Resident 1 at risk for deterioration of his medical condition, and death. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition that causes confusion, memory loss and loss of consciousness), status post (after or following) a stroke with right side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a slight paralysis or weakness on one side of the body), functional quadriplegia (the lack of ability to use one's limbs or to ambulate due to extreme debility or frailty caused by another medical condition without physical injury or damage to the spinal cord), hypertension ([HTN] high blood pressure [BP]), dysarthria (speech that is slurred slow and difficult to understand), benign prostatic hypertrophy ([BPH] a condition in which the prostate is enlarged causing slow urine flow or blockage of urine from the bladder), a urinary tract infection ([UTI] an infection that affects all or part of the urinary tract including the bladder and kidneys), hypothyroidism (a condition when there is not enough hormones in the body to control the body's use of energy), generalized weakness and a history of repeated falls. The Face Sheet indicated there was no responsible person listed only a contact person (the significant other). The contact person listed had no documented contact information, such as address or telephone number. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was not able to make decisions for himself, was incontinent of bladder and bowel functions, was non ambulatory, and was totally dependent on two or more staff to complete his activities of daily living ([ADLS] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555785	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Care Center	1880 Dawson Avenue Signal Hill, CA 90806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's H&P dated 11/23/2024, the H&P indicated Resident 1 was able to make his needs known but could not make medical decisions. During a review of Resident 1's Physician's Order, dated 11/22/2024, the Physician's Order indicated Resident 1 was incapable of giving informed consent (a process where a patient is given clear and comprehensive information about a particular action, procedure, or situation, to ensure they understand the risks, benefits, alternatives, and potential consequences of medical interventions) and he was unable to participate in his plan of care. During a review of Resident 1's H&P dated 11/23/2024, the H&P indicated Resident 1 was able to make his needs known but could not make medical decisions. During a review of Resident 1's Physician's Order, dated 11/22/2024, the Physician's Order indicated Resident 1 was incapable of giving informed consent (a process where a patient is given clear and comprehensive information about a particular action, procedure, or situation, to ensure they understand the risks, benefits, alternatives, and potential consequences of medical interventions) and he was unable to participate in his plan of care. During a review of Resident 1's untitled Care Plan, dated 11/25/2024, the Care Plan indicated Resident 1 needed retraining in skills to enable his return to community. The Care Plan's goal was for Resident 1 to be safely discharged to an appropriate level of care with interventions including collaboration with Resident 1, his RP and physician to ensure Resident 1's appropriate placement. The Care Plan indicated to follow up with home health services such as physical therapy ([PT] treatment that helps improve how the body performs physical movement), occupational therapy ([OT] treatment that focuses on helping individuals improve their ability to engage in meaningful ADLs) and nurse services, to provide education and training to Resident 1, and his RP as needed for safety, discharge instructions and a detailed summary of Resident 1's care upon discharge to assure his continuity of care. During a review of Resident 1's Physician's Order, dated 11/22/2024 the Physician's Order indicated the following medications were prescribed to Resident 1: 1. Norvasc (a medication used to treat high blood pressure) 2.5 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) one tablet daily for HTN hold for systolic BP (the top number in a BP reading) of less than 100. 2. Doxazosin Mesylate (a medication used to treat urinary problems caused by an enlarged prostate, which includes difficulty urinating) 2.0 mg one tablet daily for BPH. 3. Lipitor (a medication that lowers cholesterol) 20 mg 1 tablet by mouth at bedtime for hyperlipidemia (abnormally elevated levels of any or all lipids [fats] in the blood). 4. Hydrocodone Acetaminophen (a pain medication) 5/325 mg one tablet every four hours as needed for moderate to severe pain 5. Levoxyl (a medication that contains and replaces a hormone) 50 micrograms ([mcg] a metric unit of measurement, used for medication dosage and/or amount) one tablet daily for hypothyroidism. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Protonix (a medication that treats gastroesophageal reflux ([GERD] a condition in which the stomach contents leak backwards from the stomach into the esophagus [the tube from the mouth to the stomach], and stomach ulcers) 40 mg one tablet daily for GERD. During a review of Resident 1's Physician's Progress Notes dated 11/27/2024, the Physician's Progress Notes indicated Resident 1 was admitted to the facility on [DATE] with a chief compliant of weakness and an altered level of consciousness ([ALOC] a condition of not being alert, awake or able to understand) for skilled rehabilitation (care that can help a person get back, keep, or improve abilities needed for daily life) with a goal of retraining Resident 1 to improve his coordination/balance, self-care abilities, pain management, and to monitor his cognition to reduce the risk of falls and accidents. During a review of Resident 1's Nurses Progress Notes dated 11/25/2024 and timed at 4:14 p.m., and 5:43 p. m., and a subsequent Nurses Progress Notes dated 11/27/2024 and timed at 3:15 p.m., the Nurses Progress Notes indicated Resident 1's significant other (who was identified only as Resident 1's contact without any contact information provided) refused to sign Resident 1's admission documents, treatment plan and refused to provide her contact information. The Nurses Progress Notes indicated Resident 1's significant other wanted to take Resident 1 out of the facility. During a review of Resident 1's Social Services assessment dated [DATE] and timed at 3:39 p.m., the Social Services Assessment indicated Resident 1's significant other stated she would take Resident 1 out of the facility. During a review of Resident 1's Skilled Charting dated 11/28/2024 and timed at 1:14 p.m., the Skilled Charting indicated Resident 1's significant other threatened to take Resident 1 out of the facility AMA because she felt Resident 1 was not making any progress. During a review of the facility's video surveillance with a date of 11/30/2024 and time stamped from 2:09 a.m. to 2:10 p.m., with the Administrator (ADM) present, the video surveillance indicated the following: 1. There was no receptionist in the lobby or staff attending the front door 2. At 2:09 and 44 seconds p.m., Resident 1 observed sitting in a wheelchair dressed in his personal clothes (blue or black top) with a white bag on top of his lap and another white bag strapped on the back of the wheelchair. A blonde female was observed wearing a beige sweater and blue jeans, she was pushing the wheelchair and Resident 1 towards the lobby. The front door in the lobby was observed opening and Resident 1 and the significant other were seen leaving the building and turning left by the facility's porch towards the ramp. 3. A few seconds after Resident 1 and the significant other were observed leaving through the facility's front door and before the door automatically closed, a tall male staff wearing a black top, blue pants and a blue beanie was observed walking out of the opened front door. The ADM identified the male staff as the facility's weekend receptionist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 11/30/2024 and timed at 3:24 p.m., the SBAR indicated at 2:30 p.m., on 11/30/2024, the facility did not find Resident 1 in his bed and Resident 1's roommate reported Resident 1's significant other took Resident 1 for a walk. During a review of Resident 1's Social Service Note dated 12/2/2024 and timed at 5:48 p.m., the Social Service Note indicated Resident 1, and the significant other were located at a homeless encampment. During an interview on 12/4/2024 at 11 a.m., Resident 2 stated he was Resident 1's roommate and Resident 1 was not able to express himself and would only mumble. Resident 2 stated Resident 1 had a female visitor, referring to the significant other, that would visit him every other day. Resident 2 stated, on a Saturday afternoon (11/30/2024) he overheard the female visitor telling Resident 1 they were going for a walk, and they left the room with the female visitor pushing Resident 1 in a wheelchair. During a telephone interview on 12/4/2024 at 1:06 p.m., Certified Nursing Assistant 2 (CNA 2) stated she was assisting Resident 2 with his care (11/30/2024 at approximately 2:45 p.m.), when the 3 p.m. to 11 p.m., shift nurse, Licensed Vocational Nurse 2 (LVN 2), came to Resident 1's room to check on him, and Resident 1 was not in his bed. CNA 2 stated Resident 2 (Resident 1's roommate) told her and LVN 2 that Resident 1's female visitor (the significant other) took Resident 1 for a walk. CNA 2 stated Resident 1 was not able to talk well and needed help with his ADLs. CNA 2 stated, there was no communication during shift change that Resident 1's significant other had intentions of taking Resident 1 from the facility AMA. During a telephone interview on 12/4/2024 at 4:29 p.m., the facility's weekend Receptionist (REC) stated the front door in the lobby is opened remotely and he must have opened the front door for Resident 1 and the significant other on 11/30/2024 at around 2 p.m. using the remote control. The REC stated the facility was not a locked unit and there were times when Residents and/or their family members would go outside and sit on the front porch or just wheel around the parking lot for a minutes. The REC stated he was not given instructions from the facility's nursing staff to watch Resident 1 because his significant had intentions of taking the resident from the facility AMA. The REC stated if he been informed, he could have stopped them from leaving the facility until he verified if Resident 1 and his significant other were allowed to leave. The REC stated it was the responsibility of all facility staff to ensure all residents were safe and did not leave the facility or were taken from the facility without a physician's or knowledge of the facility staff. During a telephone interview on 12/4/2024 at 4:54 p.m., LVN 2 stated she was conducting resident rounds on 11/30/2024 around 2:30 p.m., when she noticed Resident 1 was not in his bed. LVN 2 stated Resident 2 informed her that Resident 1's significant other took Resident 1 on a walk about 30 minutes prior to her coming to check on him. LVN 2 stated Resident 1's significant other made threats to the facility staff multiple times that she would take Resident 1 out of the facility AMA but there were no safeguards in place to monitor Resident 1 and the significant other. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 6:05 p.m., and a subsequent interview on 12/10/2024 at 2:30 p.m., the DON stated she and other members of the facility were aware of Resident 1's significant other's intention to take Resident 1 out of the facility AMA. The DON stated they did not notify Resident 1's physician of the requested AMA and there was no change of condition (COC), or care plan created to address the significant other's intention. The DON stated Resident 1's physician should have been notified of Resident 1's and/or the significant other's intention to leave the facility AMA so the physician could have had an opportunity to speak to Resident 1 and the significant other about the risks of leaving the facility AMA. During an interview on 12/9/2024 at 2:06 p.m., the Administrator (ADM) stated the safety and supervision of the residents is the responsibility of all staff to ensure residents are safe and do not leave the facility without the staff knowledge. During a telephone interview on 12/12/2024 at 6:09 p.m., Resident 1's Physician stated Resident 1 had no capacity to give consent, he was not able to participate in his plan of care, and he had no capacity to make medical decisions. The Physician stated, although he was not sure if Resident 1's significant other had a sound mind and mental capacity to make decisions or care for Resident 1, she was the person who visited Resident 1 at the GACH, and the facility assumed she was Resident 1's RP. Resident 1's physician stated he considered Resident 1's leaving the facility with the significant other assisted elopement or kidnapping and thought the facility staff could have prevented him from leaving the facility. Resident 1's physician stated, although Resident 1 was eventually found by the facility staff, his whereabouts were unknown for two days and when he was found he was living under dire (a situation or event that causse great fear and worry)circumstances in a homeless encampment without assistance to complete his ADLS, no medication, no electricity, unsafe/unsanitary living conditions and exposure to poor weather conditions. During a review of the facility's policy and procedure (P/P) titled, Safety and Supervision of Residents revised 12/2023, the P/P indicated resident supervision is a core component of the facility's systems approach to safety and the type and frequency of resident supervision must be determined by the individual resident assessed needs and identified safety hazards and/or conditions in the environment. The P/P indicated the facility ensures the safety and supervision of the residents by: 1. Addressing the safety risks for the residents by identifying the risk factors obtained from observation of the resident, medical history, MDS, assessments and formulation of a care plan to target interventions to reduce the potential of accidents and other safety situation of the residents. 2. Implementing the interventions to reduce the risk of accidents, hazards, and other unsafe resident situation by communicating relevant specific interventions to all staff of the facility, assigning responsibility for carrying out interventions, providing training as necessary, ensuring all interventions are implemented and documented. 3. Monitoring the effectiveness of interventions by ensuring the interventions were implemented correctly and consistently and evaluating the effectiveness of the interventions and revised as needed.nsistently and evaluating the effectiveness of the interventions and revised as needed.