California Department of Public Health

rcvd 04.29.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA010000003	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE REHABILITATION & BEHAVIORAL HEALT	850 SONOMA AVE SANTA ROSA, CA 95404

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C 000	Initial Comments The following reflects the findings of the California Department of Public Health during a Change of Ownership survey. The facility census was 147. The sample size was 8.	C 000	On 4/25/25, the Administrator completed a revision of the facility's policy and procedure (P&P) for PASSR to 1) include the definition of a significant change and 2) address what to do when a resident is noted to have a significant change of condition	4/25/25
C 675	T22 DIV5 CH3 ART3-72301(b) Required Service (b) Skilled nursing facilities caring for patients who are mentally disordered and whose needs for a special treatment program are identified shall also meet the requirements for a special treatment program service. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Resident 14 received a level II PASSR (Preadmission Screening and Resident Review - a federal requirement ensuring individuals with serious mental illness (SMI), intellectual disabilities (ID), or related conditions are not inappropriately placed in Medicaid-certified nursing facilities (NFs) and receive appropriate services) evaluation. This failure resulted in resident 14's exclusion from a complete mental health evaluation for appropriate facility placement, and non-receipt of available mental-health resources from the California Department of Developmental Services (DDS). Findings: During a record review of Resident 14's "Admission Record", printed 4/2/25, it indicated Resident 14 was originally admitted to the facility on 2/8/17.	C 675	On 4/28/25, the Administrator revised the P&P with the facility's current PASSR system authorized users and the with the Interdisciplinary Team (IDT), the requriement that a Resident Review (RR) must be initiated by submitting a Level I Screening upon a resident's significant change in condition. On 4/28/25, the Administrator reviewed with the Interdisciplinary Team (IDT) the definition of a "significant change of condition" The facility's current PASSR System authorized users include the Business Office Manager, Business Office Assistant, and Admission's Director. The IDT includes the Director of Nurses, Director of Staff Development, Minimum Data Set Nurse, Social Services Director, Activities Director, Rehabilitation Director, Medical Records Designee, and Administrator The IDT will review changes of condition as definied int the P&P during morning stand-up meetings and commmunicate need to submit Level I Screening to PASSR systems users as needed. The Medical Record's Designee will audit changes of conditions and for completion of the process and report findings to IDT. System Effectiveness will be evaluated during the facilitiy's monthly Quality Assurance Performance Improvement Commiotte meetings for three (3) months	4/28/25

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dal — TITLE: Administrator — (X6) DATE: 4/28/25

POC accepted ō Megan Rose, DON
4/29/25
BIC date 4/28/25

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C 675	Continued From page 1 During a record review of Resident 14's "MDS-C (Minimum Data Set-section which focuses on cognitive patterns in nursing home residents, including attention, orientation, and ability to register and recall new information)" dated 3/10/25, it indicated Resident 14 had a BIMS (Brief Interview of Mental Status–a tool used in nursing homes and long-term care facilities to assess and monitor cognitive function, with scores ranging from 0 to 15, where higher scores indicate better cognitive function) score of 11, indicating moderate cognitive impairment. During a concurrent observation and interview on 4/3/25 at 9:48 am with Resident 14 and the MDS Nurse (MDSN), Resident 14 was asked to state the current year, month and day of the week. Resident 14 could not answer any of these questions correctly and could not recall three one-syllable words (sock, blue, and bed) after one minute. This assessment would indicate a current BIMS score of three (3), indicating severe cognitive impairment. During a review of Resident 14's "MDS-I", dated 3/10/25, it indicated Resident 14 had diagnoses including Alzheimer's Disease (a progressive neurodegenerative (when nerve cells in the brain or nervous system lose function over time and ultimately die) disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia) non-Alzheimer's dementia (a range of neurodegenerative conditions, other than Alzheimer's disease, that cause dementia), anxiety, depression (a serious mental health condition that can affect how you feel, think, and act, and it's more than just feeling sad for a few days), and bipolar disorder (a mental illness characterized by extreme mood	C 675		

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swings, ranging from periods of intense highs (mania/hypomania) to lows (depression), affecting energy, thinking, behavior, and sleep).

During a review of Resident 14's "PASRR Level 1 Screening Document", dated 2/8/17, completed by the facility, it indicated Resident 14 had a diagnosed mental illness, and the screening was "Positive" for a level II PASSR screening.

During a review of Resident 14's "PASSR Level 1 Screening" for a re-admission, dated 11/21/22, it indicated Resident 11 had a diagnosed mental illness and a level 2 PASRR screening was required.

During a review of correspondence from Department of Health Care Services (DHCS) PASRR Section, dated 12/9/22, it indicated a Level II PASRR screening could not be conducted because "the individual was isolated as a health or safety precaution".

During a review of correspondence from DHCS Clinical Assurance Division, dated 3/1/25, it indicated Resident 14 did not require a Level II PASRR screening because Resident 14 did not have a severe mental illness.

During a concurrent interview and record review on 4/3/25 at 1:30 p.m. with the facility Business Manager (BMG), Resident 14's PASRR documentation was reviewed. BMG stated it was the acute care hospitals (ACH) responsibility to complete the PASRR level I. BMG stated she did not know what to do if the ACH did not accurately complete the PASRR, and stated there was no specific facility policy for PASRR. Additionally, BMG stated she did not know who would complete a PASRR if a resident was diagnosed

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with a mental illness while living in the facility. BMG stated accurate PASRR documentation is important so residents get appropriate services, or to be placed in the correct type of facility. BMG stated that her role was just the "business end" of the PASSR process, stating the facility does not get paid if there is Level II PASRR is required and isn't followed up on.

During an interview on 3/5/25 at 1:58 p.m. with the facility Administrator (ADM), ADM stated a Level II PASSR screening should have been conducted for Resident 14, and there is obviously a "hole" in the current PASRR process. The ADM stated the need for a specific and detailed policy to closely monitor incoming resident PASRRs, and to appropriately place residents who have a change in mental condition.

During a record review of facility policy and procedure titled, "Behavioral Assessment, Intervention and Monitoring", revised 2019, it indicated "Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment", and "a. All residents will receive a Level I PASARR screen prior to admission. b. If the level I screen indicates that the individual may meet the criteria for a mental disorder ...he or she will be referred to the state PASARR representative for the Level II (evaluation and determination) screening process. c. The Level II evaluation will be used when conducting the resident assessment and developing the care plan ...new onset or changes in behavior that indicated a newly evident or possible serious mental disorder ...will be referred for a PASARR Level II evaluation."

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C1270	Continued From page 4	C1270		
C1270	T22 DIV5 CH3 ART3-72321(b) Nursing Service--Patients with Infectious Dis (b) The facility shall adopt, observe and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as necessary. This Statute is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure: 1.Hand Hygiene (HH, hand washing) was offered to the residents after meals. 2.Staff were performing HH prior to preparing medications. 3.Staff were performing HH prior to donning and doffing gloves These failures could result to the spread of infections, including norovirus (a very contagious virus that causes vomiting and diarrhea), respiratory illnesses, and nosocomial infections (an infection that is acquired in a healthcare setting) like Methicillin Resistant Staphylococcus Aurea (MRSA, bacteria that is resistant to many common antibiotics, making infections harder to treat) potentially endangering residents and staff. Findings: 1.During an observation on 4/1/25 at 12:35 p.m., staff did not offer HH to Resident 3 after she finished her lunch. During an observation on 4/1/25 at 12:38 p.m.,	C1270	On 4/7/25-4/10/25 all staff were In-serviced on Hand Washing/Hand Hygiene Policy and Procedure (P&P) by Director of Nursing (DON), Director of Staff Development (DSD), Assistant Director of Staff Development (ADSD) and Infection Preventionist (IP) to include: 1) Offering Hand Hygiene (HH) to residents after meals 2) Utilizing HH prior to preparation of medications 3) Utilizing HH prior to donning and doffing of gloves IP, DSD, and ADSD will observe and monitor: (1) Staff offering HH to residents after meals (2) Utilizing HH prior to preperation medications (3) Utilizing HH prior to donning and doffing of gloves IP, DSD, or ADSD will audit three times (3) a week for 3 weeks, twice (2) weekly for 2 weeks and then once (1) per week for 1 week. Random audits for one (1) month. System effectiveness will be evaluated during the facility's monthly Quality Assurance Performance Improvement Committe for three (3) months	4/10/25 5/2/25 5/19/25 5/30/25

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C1270	Continued From page 5 staff did not offer HH to Resident 4 after he finished his lunch. During an observation on 4/1/25 at 12:40 p.m., staff did not offer HH to Resident 5 after he finished his lunch. During an observation on 4/1/25 at 12:44 p.m., staff did not offer HH to Resident 6 after he finished his lunch. During an interview on 4/1/25 at 12:46 p.m. the Mental Health Worker (MHW) stated the facility policy was to offer HH to the residents before and after meals for infection control. MHW stated not offering HH to the residents before and after meals could lead to sickness such as diarrhea and infection. During a concurrent observation and interview on 4/1/25 at 12:47 p.m., Unlicensed Staff C stated HH should be offered to the residents before and after meals for infection control. Unlicensed Staff C stated germs were everywhere and it was important to make sure hands were clean to prevent infection and illness such as diarrhea. Unlicensed Staff C verified they did not offer HH to Residents 3, 4, 5 and 6 after they finished their lunch. Unlicensed Staff C stated not performing HH before and after meals could result in residents getting sick. Unlicensed Staff C stated HH was important for infection control. During an interview on 4/2/25 at 4:46 p.m., the nurse manager (NM) stated staff should offer HH to the residents before and after meals. NM stated HH is important to prevent infection. NM stated HH could prevent residents from getting sick, contracting virus, bacteria or parasite.	C1270		

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C1270	Continued From page 6 2. During a concurrent observation and interview on 4/2/25 at 12:10 p.m., Licensed Psych Technician (LPT) D did not perform HH prior to starting the medication pass. During an interview on 4/2/25 at 4:46 p.m., NM stated staff should perform HH prior to giving medications to the residents. NM stated HH protects the residents from infection and prevents the spread of disease. 3. During a concurrent observation and interview on 4/2/25 at 4:01 p.m., LPT E did not perform HH prior to donning gloves and after doffing gloves. LPT E verified not performing HH prior to donning and after doffing gloves. LPT E stated the facility policy indicated to perform HH prior to donning and after doffing gloves. LPT E stated not performing HH could result in potential spread of deadly germs to the patients. During an interview on 4/2/24 at 4:46 p.m., the NM stated it was the facility's policy for staff to perform HH before donning and after doffing gloves to prevent contamination and spread of disease. A review of the facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene, revised 8/2015, it indicated to use an alcohol based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations ...before and after eating or handling food ...before preparing or handling medications ...after removing gloves.	C1270		
C1990	T22 DIV5 CH3 ART3-72357(i) Pharmaceutical Service--Labeling and Storage	C1990		

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C1990	Continued From page 7 (i) Drugs shall be accessible only to personnel designated in writing by the licensee. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow medication storage and administration policy when nursing staff left a medication cart unlocked during Resident 16's medication pass. This failure had the potential for unauthorized staff and resident access to multiple resident's medications. Findings: During a review of Resident 16's "Admission Record", printed 4/2/25, it indicated Resident 16 was admitted to the facility on 3/10/25, with diagnoses including surgical aftercare, cardiac arrest (a sudden, sometimes temporary, cessation of function of the heart), heart failure (when the heart can't pump enough blood to meet the body's needs, often due to a weakened or stiff heart muscle, leading to fluid buildup in the lungs and other tissues), and type 2 diabetes millitus (a chronic condition that happens when you have persistently high blood sugar levels). During a review of Resident 16's "MDS-C (Minimum Data Set-section which focuses on cognitive patterns in nursing home residents, including attention, orientation, and ability to register and recall new information)", dated 3/19/25, it indicated Resident 16 had a BIMS (a tool used in nursing homes and long-term care facilities to assess and monitor cognitive function, with scores ranging from 0 to 15, where higher scores indicate better cognitive function) of 15, indicating intact cognitive function.	C1990		

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C1990	Continued From page 8 During a review of Resident 16's "Order Summary Report", dated 4/2/25, it indicated Resident 16 was prescribed: Novolog (insulin medication-a hormone that helps the body regulate blood sugar levels. It is used to treat diabetes, a condition where the body does not produce or use insulin effectively) Flexpen 100 Unit/ml (milliliter-a unit of measure) Solution pen-injector with sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal) dosage instructions (151-200 BG (blood glucose, or blood sugar level) = 2 units), subcutaneously (the insertion of medications beneath the skin either by injection or infusion) before meals and at bedtime for DM (diabetes millitus). Start date 3/13/25, no end date. During a concurrent observation and interview on 4/2/25 at 1:01 p.m. with Licensed Nurse C (LN C), Resident 16's noon medication pass was observed. After obtaining a blood glucose reading of 164 from Resident 16, LN C prepared Novolog 100 units/ml pen-injector at the hallway two (2) mobile medication cart, approximately two (2) feet outside Resident 16's bedroom doorway. After preparing the medication for administration, LN C entered Resident 16's room, administering the injection subcutaneously in Resident 16's right upper arm. During this time, LN C's back was positioned toward Resident 16's bedroom door, and the medication cart was left unlocked, unattended and out of LN C's direct line of sight. LN C acknowledged the cart was unlocked and should have been locked while she did not have direct sight of it. During an interview on 4/3/25 at 10:55 a.m. with the Director of Nursing (DON), the DON stated	C1990		

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C1990	Continued From page 9 that medications should be locked and secured to prevent unauthorized access to them from unlicensed staff and other residents who frequent the hallways. During a review of facility policy and procedure (P & P) titled, "Administering Medications", revised 4/2019, it indicated "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide." During a review of facility P & P titled, "Storage of Medications", revised 11/2020, it indicated "compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use. Unlocked medications carts are not left unattended."	C1990	From 4/4/2025 through 4/7/2025, the DON, DSD and ADSD completed 1:1 inservices with licensed staff regarding the facility policy and procedure titled Storage of Medications. Medication carts must be kept locked when unattended. DON, IP, MDS, ADSD, or DSD will monitor medication carts being locked when unattended 3 times a week for 2 weeks DON, IP, MDS, ADSD or DSD will monitor medication carts being locked when unattended 2 times a week for 2 weeks DON, IP, MDS, ADSD or DSD will monitor medication carts being locked when unattended 1 time a week for 2 weeks DON, IP, MDS, ADSD or DSD will random monitor medication carts being locked when unattended for 1 month. System effectiveness will be evaluated during the facility's monthly Quality Assurance Performance Improvement Committee meetings for three (3) months	4/7/2025 4/18/2025 5/2/2025 5/16/2025 6/16/2025
C2040	T22 DIV5 CH3 ART3-72357(n) Pharmaceutical Service--Labeling and Storage (n) Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has ben discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within 90 days of the date the drug order was discontinued, unless the drug is reordered within that time. This Statute is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to dispose of unused and discontinued medication per the facility's policy on disposal of medication, when: 1. Medication of two discharged residents (Resident 9 and Resident 10) were left inside the	C2040	From 4/4/2025 through 4/7/2025, the DON, DSD and ADSD completed 1:1 inservices with licensed staff regarding the facility policy and procedure titled Discarding and Destroying Medications. Licensed staff will follow the facility protocol for proper disposal and destruction of unused and discontinued medications. DON, IP, MDS, ADSD or DSD will monitor for proper disposal and destruction of unused and discontinued medications 3 times a week for 3 weeks DON, IP, MDS, ADSD or DSD will monitor for proper disposal and destruction of unused medications 2 times a week for 2 weeks. DON, IP, MDS, ADSD or DSD will monitor for proper disposal and destruction of unused and discontinued medications 1 time a week for 2 weeks. DON, IP, MDS, ADSD or DSD will monitor for proper disposal and destruction of unused and discontinued medication randomly for 1 month.	4/7/2025 4/18/2025 5/2/2025 5/16/2025 6/16/2025

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C2040	Continued From page 10 refrigerator of one of three medication rooms. 2. Discontinued medication of two residents (Resident 11 and Resident 12) were disposed in their original containers in resealable plastic bags in the disposal bin in one of three medication rooms. 3. Discontinued medications and birth control pills were left intact and undisposed in a disposal bin in one of three medication rooms. 4. Discontinued medication of one resident (Resident 13) was left with other medications in one of three medication carts. These failures had the potential for discontinued medication to be used for another resident leading to accidental poisoning, overdose or other serious consequences. Findings: During an observation and subsequent interview on 4/1/25 at 3:56PM, a NovoLin R (branded name of insulin, a medication to manage diabetes) FlexPen (a pre-filled, disposable insulin pen that delivers doses in one-unit increments) containing 100 units of Humulin R (regular insulin) per milliliter (ml - metric unit of measurement, used for medication dosage and/or amount) belonging to Resident 9, and a vial (small, cylindrical container made of glass) of Cathflo Acti (injectable Anteplase -medication used to dissolve blood clots in the emergency treatment of conditions like acute myocardial infarction (heart attack), acute ischemic stroke, and pulmonary embolism) 2 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) for Resident 10 were left in the refrigerator in the medication room of Nurse Station 2. On subsequent interview, LN E stated both Residents 9 and 10 were already discharged. LN	C2040	System Effectiveness will be evaluated during the facility's monthly Quality Assurance Performance Improvement Committee meetings for three months.	

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C2040	Continued From page 11 F who was seated near the Medication room door confirmed both residents were discharged. A review of Resident 9's electronic medical record in PointClickCare (PCC- electronic health record (EHR) system primarily used in the long-term care industry) titled, Admission/Re-admission Resident Data Collection, indicated she was admitted on 1/23/25. A Nursing Progress Note dated 2/20/25 indicated Resident 9 was discharged on the same date. A review of Resident 10's electronic medical record in PointClickCare titled, Admission/Re-admission Resident Data Collection, dated 1/1/25, indicated she was admitted on 1/1/25. A Nursing Progress Note dated 2/14/25 indicated Resident 10 was discharged on the same date. During an observation and subsequent interview on 4/1/25 at 4:11PM a disposal bin containing various colored pills, capsules, and purple jelly/gummy candies including two packs of Nora-BE birth control pills was noted in the Medication room of Nurse Station 1. The medications were confirmed dry with a dry gloved hand. On subsequent interview, LN B stated the medication are disposed of by inserting the medications in the Drug Buster solution in a container the facility provides. During an observation and subsequent interview on 4/1/25 at 4:26PM two resealable plastic bags were noted in the disposal container in the Medication room in Nurse Station 3. One bag contained a bottle of Haloperidol (medication used to treat nervous, emotional, and mental conditions (eg, schizophrenia) 2 mg/ml for Resident 11 and the other bag contained a bottle	C2040		

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	CA010000003	A. BUILDING: _____ B. WING _____	04/04/2025

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C2040	Continued From page 12 of SPS SUS 15GM/60 for Sodium Polystyrene sulfonate suspension (medication used to treat high levels of potassium in the blood) for Resident 12. On subsequent interview, LN G stated those were medication of current residents in the facility. A review of an Order Audit Report dated 4/2/25 provided by the DON indicated Resident 11 was prescribed Haloperidol 1 mg tablet by mouth every 4 hours as needed for agitation/nausea on 11/14/24. A review of an Order Audit Report dated 4/2/25 provided by the DON indicated Resident 12 was prescribed Sodium polystyrene sulfonate combination suspension 15 gram/60 ml to be given 30 gram by mouth one time only for abnormal level potassium until 2/10/25. During observation of Nurse Station 3A medication cart and subsequent interview on 4/2/25 at 2:48 PM, Resident 13's packet of Mirtazapine 45mg tablets was noted placed diagonally among other residents' medication in the second drawer of the medication cart. On subsequent interview, LN H stated Resident 13's Mirtazapine 45 mg was discontinued because the dose was reduced to 30mg on 3/13/25. A review of Resident 13's Order Summary Report dated 1/2/25 indicated she was prescribed Mirtazapine 45 mg tablet to be given 1 tablet by mouth at bedtime for depression on 12/20/24. Further review of Resident 13's Medication Administration record for the month of March 2025 indicated in pages 2 and 3 the order to change dose from Mirtazapine 45mg 1 tablet at bedtime to Mirtazapine 30 mg 1 tablet at bedtime on 3/13/25.	C2040		

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C2040	Continued From page 13 A review of the facility's policy and procedure titled, "Disposal of Medication and Medication-related supplies", taken from the Policies and procedures - Pharmacy Services for Nursing Facilities © 2006 American Society of Consultant Phamacists and MED-PASS, Inc. (Revised January 2018) and Polaris pharmacy services dated May 2022, indicated, discontinued medication and medication left in the facility after a resident's discharge are destroyed. Destruction methods should comply with federal and state laws and regulation for medication destruction. Unused, unwanted medication should be removed from their storage area and secured until destroyed.	C2040	Type text here	
C5210	T22 DIV5 CH3 ART5-72547(a)(15) Content of Health Records (a) A facility shall maintain for each patient a health record which shall include: (15) A copy of the transfer form when the patient is transferred to another health facility. This Statute is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to notify and provide evidence the LTC Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) was provided a copy of the transfer notice for 42 out of 42 residents that were subjected to a facility-initiated discharge or transfer to the hospital from 12/2024 up to 3/2025. These	C5210	Type text here	

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C5210	Continued From page 14 failures could result in loss of patient's advocacy and protection, inappropriate discharge or transfer and missed opportunities for intervention: Findings: During a concurrent interview and discharged list for 3/2025 record review on 4/3/25 at 10:37 a.m., the program director (PD) stated the behavioral unit never notified the ombudsman of any discharges or transfers to the hospital. During an interview on 4/3/25 at 10:40 a.m., the nurse manager (NM) stated the behavioral unit had never notified the ombudsman whenever the facility discharged or transferred residents to the hospital. The NM stated he did not think they had to notify the Ombudsman so they had not been doing it. During an interview on 4/3/25 at 10:50 a.m., Licensed Nurse (LN A) stated the behavioral unit had never notified the ombudsman of residents transfers or discharges. When asked why not, LN A stated it's just something that they never had to do. During an interview on 4/3/25 at 11:16 a.m., LN B stated it was the facility's policy to notify ombudsman whenever a resident was discharged from the facility or transferred to the hospital. LN B stated it was important to ensure ombudsman was notified to protect the residents right and to ensure safe discharge from the facility. During an interview on 4/3/25 at 11:20 a.m., the Social Services Director (SSD) stated she had not notified the ombudsman of any facility driven discharges or transfers to the hospital since 12/2024. The SSD stated the ombudsman should	C5210	On 4/26/25, the Administrator reviewed the content of AFL 17-27 with the Social Services Direcor (SSD) and Behavorial Unit's Program Director (PD) and Nurse Manager (NM) for compliance. The Administrator stressed AB 940's requirement that the facility 1) must notify the local LTC Ombudsman at the same time notice is provided to the resident or resident's representative when a facility inititated transfer or discharge occurs and 2) is requried to proved a copy of the notice to the LTC Ombudsman as soon as practicable if resident is subject to a facility initiated transfer to a general acute care hospital on an emergency basis. The SSD will maintain a binder organized by year containing 1) a list of all discharged residents to date 2) copies of the facility initated transfer notices, and 3) proof of transmission of the notices to the LTC Ombudsman's office. The PD and NM will maintain the same for the Behavioral Health Unit. System effectiveness will be evaluated during the facility's monthly Quality Assurance Perfomance Improvement Committee meetings for three (3) months	4/26/25

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C5210	Continued From page 15 be notified of all discharges from the facility including hospital transfers. The SSD stated it was important to ensure the ombudsman was notified to protect residents, provide a safe discharge and to ensure discharge was appropriate. During an interview on 4/3/25 at 12:33 p.m., the administrator (Admin) stated the behavioral unit operated and was licensed under the skilled nursing facility (SNF) and as such, was bound to follow the state regulation as well. The admin stated the ombudsman should be notified of all discharges from the SNF and the behavioral unit. The admin stated it was important to notify the ombudsman of all discharges to provide added protection to residents from being inappropriately discharged. A review of the all facilities letter (AFL 17-27) indicated the facility must send notice to the local LTC Ombudsman for any transfer or discharge that is initiated by the facility.	C5210		