STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	**831 S LAKE STREET LOS ANGELES, CA 90057**

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 0622 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement facility policy titled, Transfer or Discharge Documentation, and develop safe and appropriate discharge plans, with the involvement of the Interdisciplinary Team (IDT - a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient), the resident and the resident's responsible party; inform the resident/resident responsible party of the final discharge plan; provide effective transition to the lower level of care facility; document referrals to a hospice agency; and failed to ensure the physician evaluated, identified and documented the medical and residents discharge needs for five of eight sampled residents (Residents 1, 2, 6, 7, and 8). These deficient practices resulted in the following: Resident 1 wandering away from the independent living facility and living without shelter for a week before medical responders found him wandering in a street and took him to a hospital. Resident 2 living in a friend's backyard trailer, without air conditioning, having periods of forgetfulness, which affected his taking his medications, and enrolling himself in a hospice program. Resident 6 being sent to another skilled nursing facility (Skilled Care 1), which did not have record of Resident 6 arriving or being a resident there. There was no follow up for Resident 6. Resident 7 being sent immediately from the independent living facility to another skilled care facility, due to R7's need for extensive care. Resident 8 was sent to a lower level of care facility but the Skilled Nursing Facility (SNF) did not tell the lower level of care facility about the resident's need for [MEDICAL TREATMENT] treatments (a machine is used to perform some of the functions normally managed by a healthy kidney, by cleansing the blood). This resulted in R8's hospitalization and need for emergency [MEDICAL TREATMENT] and other treatment at the hospital. A pattern of the facility's system failure to implement its policy regarding Transfer or Discharge, and to ensure residents who were unable to care for themselves and required supervision and/or assistance with care was discharged appropriately with safe placement identified. The facility discharged Residents 1, 2, 6, 7, and 8 without an IDT assessment to ensure that the discharge and the placement was appropriate and safe to meet the resident's needs. The facility's non-compliance put Residents 1, 2, 6, 7, and 8 at risk for a decline and potential for injury and harm. On [DATE], at 2:18 p.m., The Department of Public Health (Department) called an Immediate Jeopardy (IJ - a noncompliant situation which would likely cause serious harm to the health and safety of residents) in the presence of the Administrator (ADM) and the Director of Nursing (DON). The Department verbally notified the Administrator and the Director of Nursing of the failure to have systems in place to discuss and develop safe and appropriate discharge plans, with the involvement of the Interdisciplinary Team, the resident and the resident's responsible party; inform the resident/resident responsible party of the final discharge plan; provide effective transition to the lower level of care facility for Residents 1, 2, 6, 7, and 8. This failure resulted or could have resulted in the residents not receiving the medical services they needed and could have resulted in death. On [DATE] at 9 a.m., the ADM and DON provided an acceptable plan of action (POA) for correction of the IJ. The POA included the following: 1. The policy titled, Discharging the Resident was revised to address the requirements of discharge detailed in the State Operations Manual Appendix PP 2019. 2. The Director of Staff Development (DSD) developed an in-service lesson plan regarding the federal requirements for discharging and transferring residents. 3. The Licensed Social Worker, contracted with the facility, gave a directed-in-service to the Directors of Staff Development, the Administrator, the social worker assistants, and the discharge nurses regarding the federal requirements for discharging and transferring residents. 4. The Administrator posted the federal regulations in the nursing stations and in the social service office for staff reference when planning the discharges and transfers of residents. On [DATE], at 12 p.m., while onsite at the facility, the Department confirmed the implementation of the facility's corrective plan of action through interviews and record reviews. The Immediate Jeopardy was removed in the presence of the Administrator and the Director of Nursing. Findings: a.A review of R1's medical record titled Progress Notes, written by Nurse Practitioner 1 (NP1), dated [DATE], indicated R1 had a history of [REDACTED]. A review of Resident 1's (R1) medical record indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of R1's medical record titled Initial History and Physical, written by MD1, dated [DATE], indicated R1 has fluctuating capacity to understand and make decisions. A review of the Physician and Telephone Orders, dated [DATE], indicated Medical Doctor 1 (MD 1) gave a telephone order for the facility to discharge R 1 but did not indicate MD 1's signature. During an interview with Family Member 1 on [DATE] at 2:35 p.m., Family Member 1 stated that R1 had dementia and had been hit by a car while wandering in a street in the past and that the facility did not involve Family Member 1 in the planning of or notify him verbally or in writing of R1's discharge. Family Member 1 stated he wished the facility had informed him of R 1's discharge because R 1 needs a place that has locks on the doors. Family Member 1 stated R1 needed a place where he cannot wander off and keep getting hurt and picked up by ambulances again and again. During an interview the proprietor (owner) of the independent living facility (P1) that received R1 on [DATE] at 10:02 a.m., stated that her facility did not provide nursing care and did not have nurses on staff. P1 stated her facility only offered light cooking and cleaning only and provided for residents who were walking and independent. P1 stated R1 stayed at her facility less than 12 hours before he began to yell and left her facility, after which she reported R1 to the police as missing. P1 stated the skilled nursing facility did not inform her that R1 had dementia and a history of wandering from facilities or that R1 needed assistance with bathing, grooming, dressing himself and taking his medications. P1 stated her facility was not appropriate for R1. During a review of the medical record for R1, the document titled Emergency Department (ED) Provider Notes, written by MD2, dated [DATE], indicated R1 was brought to an emergency department by emergency medical responders on [DATE] after he had likely been on the streets for a week. A review of R1's medical record and a concurrent interview with the Minimum Data Set coordinator (MDS) 1 on [DATE] at 11 a.m., regarding the Section G on the Minimum Data Set (a care planning and screening tool) dated [DATE], indicated R1 needed assistance with getting in and out of bed, dressing, toileting, hygiene and bathing (resident was rated a 2 for assistance, 3 indicated extensive assistance). MDS1 stated at the time of his discharge R1 needed assistance with getting in and out of bed, dressing, toileting, hygiene and bathing. A review of R1's medical record and a concurrent interview with Social Worker Assistant (SWA)1, on [DATE] at 4:01 p.m., SWA1 stated there was no documentation of the facility informing P1 of R1's history of dementia and wandering from facilities or documentation of R1's needs for assistance and safety. A review of R1's medical record and a concurrent interview with Registered Nurse (RN)1 on [DATE] at 4:56 p.m., the document titled, Post Discharge Plan of Care, dated [DATE], did not indicate that R1 or his responsible party participated in or received documentation about R1's discharge plan of care. RN1 stated neither R1 or his responsible party participated in or received documentation about R1's

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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 0622 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) discharge. Regarding the physician order [REDACTED]. During an interview with MD 1 on [DATE] at 9 a.m., MD 1 stated he did not remember giving a telephone order for the facility to discharge R 1. During an interview with RN1, on [DATE] at 5:05 p.m., RN1 stated R1 was not appropriate for an independent living facility because he needed a lot of assistance that an independent living facility did not provide. RN 1 stated R1's medical record did not include documentation informing the assisted living facility staff of R1's needs, history of dementia, or wandering in streets. b. A review of Resident 2's (R2) medical record indicated an admission to the skilled nursing facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set ((MDS) dated [DATE], indicated R2 needed assistance of one person to transfer in and out of bed, walk using a cane, dress, toilet, and bath. A Review of the POS [REDACTED]. A review of the Physician and Telephone Orders, dated [DATE], indicated MedDir 1 gave a telephone order for the facility to discharge R 2 but did not indicate MedDir 1's signature. A review of another Physician and Telephone Orders, dated [DATE], indicated that MedDiR 1 ordered the facility to arrange for R 2 to receive hospice services after his discharge. According to a review of the Notice of Transfer/Discharge, dated [DATE], the facility notified R 2 of his discharge and discharged him on the same date of [DATE], but the form did not indicate the signature of R 2. During an interview, on [DATE] at 11 a.m., MDS1 stated and confirmed, based on the MDS, that R2 needed assistance from staff with transferring in and out of bed, walking with a cane, dressing, toileting, and bathing. During an interview on [DATE] at 4:56 p.m., Licensed vocational nurse 1 (LVN 1) stated and confirmed that R2 needed at least 20 medications a day at the time of his discharge. LVN 1 also stated R2 needed one-person-assist with most things, such as taking his medications, walking, showering, getting dressed, and getting in and out of bed, as indicated in the MDS. LVN 1 stated she filled out the Notice of transfer/Discharge instead of a physician; the facility should have given R2 30 days written notice of his discharge but did not; and R2 did not sign the notice of discharge even though he was alert and oriented and capable of signing a document. During an interview with R2 on [DATE] at 1:30 p.m., R2 stated, I am legally disabled [MEDICAL CONDITION]. R2 stated the facility discharged him to a few blocks from a friend's house who had a trailer in his backyard. R2 stayed there to stay safe from COVID (Covid-19, a respiratory disease that has caused a worldwide pandemic that has killed many people). R2 stated the trailer had no air conditioning and was very hot during the day. R2 stated he walked with a cane, because he had difficulty walking and was unsteady on his feet and gets tired easily. R2 stated he must use a ridesharing program for transportation to the grocery, and when he goes to the grocery, he cannot buy much food because he cannot carry much food back to the trailer. R2 also stated he gets confused every few days and loses track of time, which he stated was, scary, because I know I can't figure out how to do something that I know I know how to do. R2 stated he had difficulty dressing because he could not bend over well. R2 stated he loses track of time and therefore had difficulty knowing whether he took his medications and loses count when he was preparing the medications. R2 stated he must take [MEDICAL CONDITION] daily for them to be effective. R2 stated he was so depressed when the facility dropped him off that he could not think enough to take his medications because he was so overwhelmed. R2 began to cry and stated he enrolled himself in a hospice program (a service for those with terminal medical conditions that helps someone to die in a comfortable state of being). During an interview with Med Dir 1 on [DATE] at 1:45 p.m., MedDir 1 stated she did not remember giving a telephone order to discharge R2. c. A review of Resident 6's (R6) medical record indicated an admission to the skilled nursing facility on [DATE], with [DIAGNOSES REDACTED]. A review of the MDS (undated) indicated R6 needed assistance with transferring in and out of bed, walking, dressing, toileting, and bathing. A review of the Notice of Transfer/Discharge, dated [DATE], indicated the facility gave R6 his written notice of discharge on [DATE] but discharged R 6 the same day to another care facility. The Notice of Transfer / Discharge did not indicate the signature of R 6; did not indicate a reason for R 6's discharge; or the complete name, address, and phone number of R 6's receiving facility. A review of R6's Discharge/Transfer Transportation Safety Assessment, dated [DATE], indicated R6 was Unable to meet self-care needs and had several blank areas where information should have been documented. A review of the Physician and Telephone Orders, dated [DATE], indicated MD 1 gave a telephone order for the facility to discharge R6 but did not indicate MD 1's signature. A review of the Social Work Progress Notes, dated [DATE], indicated Skilled Care 1 (a skilled nursing facility for resident who cannot care for themselves) accepted R6 for admission. During an interview, on [DATE] at 11 a.m., MDS1 stated and confirmed that R6 needed assistance with transferring in and out of bed, walking, dressing, toileting, and bathing. The medical record did not indicate R6 was alert and able to make decisions. During an interview on [DATE] at 4:56 p.m., LVN 1 stated she should have completed the document but did not. LVN 1 also stated, R6 was unable to meet his self-care needs. LVN 1 stated MD 1 gave the telephone order to discharge R 6 and should have signed the telephone order but did not. A review of R6's medical record and concurrent interview with Social Worker (SW)1 on [DATE] at 4:01 p.m. During an interview on [DATE] at 4 p.m., the Admission Coordinator (AC) for Skilled Care 1 (AC) stated, We never accepted R6. He never arrived here. During another interview, on [DATE] at 12:01 p.m., the Director of Nursing (DON)2 for Skilled Care 1 stated, We have no record of admitting R6. During an interview on [DATE] at 12:21 p.m., with the Infection Preventionist (IP) for Skilled Care 1 stated, We have no record of ever admitting or accepting R6 in February of 2020, or ever. During an interview, on [DATE] at 12:45 p.m., SWA1 stated she did not know why the discharge paperwork for R6 was so incomplete. SWA1 also stated she did not know why the staff at Skilled Care 1 said R6, never arrived. A review of the medical record for R 6, and interview with LVN 1 on [DATE] at 4:56 p.m., the document titled Discharge Summary, dated [DATE], did not indicate a reason for R 6's discharge, a list of R 6's [DIAGNOSES REDACTED]. LVN 1 stated R 6's Discharge Summary should have a reason for R 6's discharge, a list of R 6's [DIAGNOSES REDACTED]. d. A review of Resident 7's medical record indicated an admission to the facility on [DATE] with [DIAGNOSES REDACTED]. The medical record indicated R7 was self-responsible and had the capacity to understand and make decisions. Notice of Transfer/Discharge, dated [DATE], indicated, the facility gave R 7 her written notice of discharge on [DATE] but discharged R 7 the same day to an independent home, and does not indicate the signature of R 7. A review and concurrent interview of R7's medical record, on [DATE] at 11 a.m., Section G of the MDS dated [DATE], indicated R7 needed assistance with transferring in and out of bed, dressing and personal hygiene; and needed extensive assistance with toileting, and bathing. MDS1 confirmed that R7 needed assistance transferring in and out of bed, dressing and personal hygiene; and needed extensive assistance with toileting, and bathing. During an interview on [DATE] at 4:56 p.m., LVN 1 stated R 7 did not sign the Notice of Transfer/Discharge but was capable of doing so, and the facility should have given R7 30 days written notice of discharge but did not. LVN1 stated R7 needs assistance with Grooming/Dressing, Bathing, Housekeeping, Shopping, Transportation to MD/Other, Therapy, Financial Management, R7 was not independent and used a wheelchair. During an interview on [DATE] at 10:15 a.m., P1 stated R7 didn't arrive at my assisted living facility. She needed too much assistance. P1 stated, R7 went to another place, a facility. During an interview on [DATE], at 3 p.m., SWA1 stated she did not know R7 did not arrive at the independent living facility as planned. SWA1 stated she did not know that the independent living facility did not provide the services that R7 needed. SWA1 stated the skilled nursing facility should not have discharged R7 to an independent living facility that could not give R7 the assistance she needed. SWA1 stated the skilled nursing facility (SNF) did not discharge R7 correctly. SWA1 stated the SNF's discharge of R7 to an independent care facility could have resulted in a delay in the medical services that R7 needed such as medication administration and extensive assistance with care needs. e. A review of Resident 8's Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of R8's medical record and a concurrent interview with MDS1 on [DATE] at 11 a.m., Section C of the MDS, dated [DATE], indicated R8's cognition was Moderately impaired. MDS1 stated and confirmed R8 had moderately impaired cognition (characterized by ongoing memory problems such as confusion, attention problems, or language difficulties). A review of R8's Minimum Data Set Section G dated [DATE], indicated R8 needed assistance with transferring in and out of bed, walking and personal hygiene and that R8 needed extensive assistance with toileting and bathing. A review of R8's Discharge/Transfer Transportation Safety Assessment, dated [DATE], indicated R8 was Unable to meet self-care needs. During an interview, on [DATE] at 4:56 p.m., LVN1 stated R8 was unable to care for herself and was receiving [MEDICAL TREATMENT] services during her stay at the SNF. LVN1 stated R8 cannot take care of herself and the physician should have ordered for the facility to arrange for R8 to receive [MEDICAL TREATMENT] services at a lower level of care facility. LVN1 stated the facility should have conveyed to the independent care facility that R8 required [MEDICAL TREATMENT] but did not. LVN 1 stated the medical record for R 8 does not include a Discharge Summary and that a physician did not write a Discharge Summary for R 8. During an interview, on [DATE] at 5:15 pm, the ADM stated the physicians for R 1, R 2, R 6, and R 8 should have signed their telephone orders to discharge the residents but did not. During an interview on [DATE] at 3:15 p.m., SWA1 stated she knew R8 was receiving [MEDICAL TREATMENT] services but did not arrange for such services to continue at the independent living facility or tell the independent living facility to do so. SWA1 stated R8's medical record did not indicate the SNF involved R8's family in the discharge planning or informed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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 0622 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) family of R8's discharge to a lower level of care. A review of R8's Physician and Telephone Orders, dated [DATE], indicated a physician ordered the facility to discharge R8 to a lower level of care and arrange for R8 to receive home health services (a service involving a medical or nursing provider coming to a patient's residence and performing medical or nursing care as ordered by a physician). A review of the document titled Physician and Telephone Orders, dated [DATE], indicated MD 2 gave a telephone order for the facility to discharge R 8 but did not indicate MD 2's signature. A review R8's medical record included a document titled Emergency Department Encounter Note, written by MD6, on [DATE], three days after R8's discharge from the SNF. The ED note indicated R8 did not have [MEDICAL TREATMENT] for five days after the SNF discharged her to a lower level of care, for which she suffered very high blood pressure, difficulty breathing, and required emergency [MEDICAL TREATMENT] and other treatment at the hospital. The ED Note indicated MD6 stated, R8 conditions had not been treated and R8 could have died as a result. During interviews on [DATE] at 5:05 p.m. and 5:10 p.m. respectively, RN1 and LVN1 stated the facility did not discharge Residents 1, 2, 6, 7, and 8 correctly. RN1 stated, Not following the state and federal regulations for discharging a resident can lead to dangerous situations. During an interview with ADM on [DATE] at 5:15 p.m., The Administrator stated the facility's policy and procedure for transfers and discharges did not address all the state and federal requirements for transfers and discharges. The Administrator stated the physicians of Residents 1, 2, 6, 7, and 8 should have documented the reasons for their discharges but did not. A review of the facility's policy and procedures titled, Transfer or Discharge Documentation, revised [DATE], indicated 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: a. The transfer or discharge is necessary forth resident's welfare, and the resident's needs cannot be met in the facility; or b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. A review of the facility's policy and procedures titled, Telephone Orders, revised ,[DATE], indicated, Telephone orders must be countersigned by the physician during his or her next visit.
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify five of eight sampled residents (R1, R2, R6, R7 and R8) or the resident's responsible party, in writing, about the residents proposed transfer and discharge to an equal or lower level of care, as soon as possible, before the transfer or discharge. This deficient practice denied the residents and their responsible parties of their right to appeal their discharges or transfers, seek advocacy from the Ombudsman office, or make safe and appropriate arrangements prior to the residents leaving the facility. Findings: a. A review of Resident 1's (R1) medical record indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. During an interview with Family Member 1 on 4/13/2020 at 2:35 p.m., Family Member 1 stated that R1 had dementia and had been hit by a car while wandering in a street in the past and that the facility did not involve Family Member 1 in the planning of or notify him verbally or in writing of R1's discharge. Family Member 1 stated he wished the facility had informed him of R1's discharge because R1 needs a place that has locks on the doors. Family Member 1 stated R1 needed a place where he cannot wander off and keep getting hurt and picked up by ambulances again and again. A review of the medical record for R1, and a concurrent interview with Registered Nurse 1 (RN1) on 4/14/2020 at 4:56 p.m., the document titled Notice of Transfer/Discharge, dated 4/7/2020, indicated the facility notified R1 of his discharge and discharged him on the same date of 4/7/2020. RN 1 stated that R1 had dementia; the facility should have given R1 and his responsible party written notice of R1's discharge at least 30 days before his discharge or as soon as possible, but did not. RN 1 stated R1 or his responsible party signed his Notice of transfer/Discharge. During an interview, on 4/14/2020 at 4:56 p.m., the Administrator (ADM) stated that R1 had dementia; there was no written documentation in the medical record of R1 that indicated the family of R1 or R1 received written notice of his discharge at least 30 days before the discharge or as soon as possible. The ADM stated neither R1 or the family of R1 signed R1's Notice of Transfer/Discharge. b. According to a review of the Notice of Transfer/Discharge, dated 4/1/2020, the facility notified Resident 2 (R2) of his discharge and discharged him on the same date of 4/1/2020, but the form did not indicate the signature of R2. During an interview with Licensed Vocational Nurse 1 (LVN 1), on 4/14/2020 at 4:56 p.m., LVN 1 stated she filled out the Notice of transfer/Discharge instead of a physician; the facility should have given R2 30 days written notice of his discharge but did not. LVN 1 stated R2 did not sign the notice of discharge even though he was alert and oriented and capable of signing a document. During an interview with R2 on 4/17/2020 at 1:30 p.m., R2 stated the facility did not give him written 30-days' notice of his discharge. R2 stated he repeatedly asked for written notice of discharge, but the facility would not give him a copy. R2 stated he repeatedly asked for the exact address of the location he was being discharged to but the facility did not give it to him, so he had to seek permission for a friend to stay in the friend's backyard trailor. R 2 stated that the way the facility discharged him was dangerous and began to cry. c. A review of Resident 6's (R6) medical record indicated an admission to the skilled nursing facility on 2/18/2020, with [DIAGNOSES REDACTED]. A review of the MDS (undated) indicated R6 needed assistance with transferring in and out of bed, walking, dressing, toileting, and bathing. A review of the Notice of Transfer/Discharge, dated 2/7/2020, indicated the facility gave R6 the written notice of discharge on 2/26/2020 but discharged R6 the same day to another care facility. The Notice of Transfer / Discharge did not indicate the signature of R6; did not indicate a reason for R6's discharge; or the complete name, address, and phone number of R6's receiving facility. During an interview, on 4/14/2020 at 12:45 p.m., Social Worker Assistant 1 (SWA 1) stated she did not know why the discharge paperwork for R6 was so incomplete. During an interview on 4/14/2020 at 4:56 p.m., LVN 1 stated R6 did not sign his Notice of Transfer/Discharge but was capable of doing so. LVN 1 stated the reason for R 6's discharge should be indicated but was not, the complete name, address, and phone number of R6's receiving facility should be indicated but were not, and the facility should have given R6 30 days written notice of discharge, but did not. d. A review of Resident 7's medical record indicated an admission to the facility on [DATE] with [DIAGNOSES REDACTED]. The medical record indicated R7 was self-responsible and had the capacity to understand and make decisions. A review of the Notice of Transfer/Discharge, dated 4/6/2020, indicated the facility gave R7 a written notice of discharge on 2/7/2020 but discharged R7 the same day to an independent home, and did not indicate the signature of R7. During an interview with LVN 1, on 4/14/2020 at 4:56 p.m., LVN 1 stated R7 did not sign the Notice of Transfer/Discharge but was capable of doing so, and the facility should have given R7 30 days written notice of discharge but did not. During an interview on 4/22/2020, at 3 p.m., SWA 1 stated the skilled nursing facility should not have discharged R7 to an independent living facility that could not give R7 the assistance she needed. SWA1 stated the skilled nursing facility (SNF) did not discharge R7 correctly. SWA1 stated the SNF's discharge of R7 to an independent care facility could have resulted in a delay in the medical services that R7 needed such as medication administration and extensive assistance with care needs. e. A review of Resident 8's Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Notice of Transfer/Discharge, dated 7/15/19, indicated the facility gave R8 a written notice of discharge on 7/15/2020 but discharged R8 the same day to an independent home, and did not indicate the complete name, address, and contact information of R8's receiving facility. A review of the MDS, dated [DATE], indicated R8's cognition was moderately impaired (characterized by ongoing memory problems such as confusion, attention problems, or language difficulties). During an interview, on 4/14/2020 at 4:56 p.m., LVN 1 stated R8's Notice of Transfer/Discharge should indicate the complete name, address, and contact information of R8's receiving facility but it did not and the facility should have given R8 30 days notice of discharge, but did not. During an interview, on 4/14/2020 at 4:57 p.m., the ADM stated the medical records of R1, R2, R6, R7, and R8 did not indicate that they received written notices of their discharges at least 30 days before the facility discharged them, or as soon as practicable and that the residents could have signed their written notices of discharge, but did not. During an interview with MedDiR 1, on 4/22/2020 at 1:42 p.m., MedDiR 1 stated that the facility should have given R1, R2, R6, R7, and R8 30 days of notice before their discharges, but did not. A review of the facility's policy and procedures titled, Transfer or Discharge Documentation, revised 5/14/19, and the policy titled, Discharging the Resident, indicated there was no reference to the resident or resident's responsible party receiving, in writing, a notice of proposed discharge.
F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician signed and dated the discharge orders for five of eight sampled residents (R 1, R 2, R3, R 6 and R 8). These residents were transferred or discharged from the facility when their physician's did not sign the telephone orders to discharge them. This deficient practice had the potential to result in unsafe and inappropriate discharge when the physician did not take an active role in supervising the care of the residents and review the resident's total program of care. Findings: a.A review of Resident 1's (R1) medical record indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Initial History and Physical, written by Medical Doctor 1 (MD 1), dated 2/21/2020, indicated R1 has fluctuating capacity to understand and make decisions A review of the Physician and Telephone Orders, dated 4/7/2020, indicated Medical Doctor 1 (MD 1) gave a telephone order for the facility to discharge R1 but did not indicate MD 1's signature. During an interview, on 4/14/2020 at 4:56 p.m., RN 1 stated MD 1 gave a telephone order for the facility to discharge R1 and should have signed the telephone order but did not. During an interview, on 4/30/2020 at 9 am, MD 1 stated he did not remember giving a telephone order for the facility to discharge R1. b. A review of Resident 2's (R2) medical record indicated an admission to the skilled nursing facility on 11/29/19 with [DIAGNOSES REDACTED]. A review of the Physician and Telephone Orders, dated 4/1/2020, indicated MedDir 1 gave a telephone order for the facility to discharge R2 but did not indicate MedDir 1's signature. During an interview on 4/14/2020 at 4:56 p.m., Licensed vocational nurse 1 (LVN 1) stated and confirmed that R2 needed at least 20 medications a day at the time of his discharge. LVN 1 also stated R2 needed one-person-assist with most things, such as taking his medications, walking, showering, getting dressed, and getting in and out of bed, as indicated in the MDS. LVN 1 stated she filled out the Notice of transfer/Discharge instead of a physician; the facility should have given R2 30 days written notice of his discharge but did not; and R2 did not sign the notice of discharge even though he was alert and oriented and capable of signing a document. During an interview with MedDir 1 on 4/24/2020 at 1:45 p.m., MedDir 1 stated she did not remember giving a telephone order to discharge R2. c. A review of the Physician and Telephone Orders, dated 4/7/20, indicated MD 1 gave a telephone order to discharge R3 but did not indicate MD 1's signature. During an interview with LVN 1 on 4/14/2020, at 4:56 p.m., LVN 1 stated MD 1 gave a telephone order to discharge R3 and should have signed the telephone order but did not. d. A review of Resident 6's (R6) medical record indicated an admission to the skilled nursing facility on 2/18/2020, with [DIAGNOSES REDACTED]. A review of the Notice of Transfer/Discharge, dated 2/7/2020, indicated the facility gave R6 a written notice of discharge on 2/26/2020 but discharged R6 the same day to another care facility. The Notice of Transfer / Discharge did not indicate the signature of R6; did not indicate a reason for R6's discharge; or the complete name, address, and phone number of R 6's receiving facility. A review of the Physician and Telephone Orders, dated 2/26/2020, indicated MD 1 gave a telephone order for the facility to discharge R6 but did not indicate MD 1's signature. During an interview with LVN 1, on 4/14/20 at 4:56 p.m., LVN 1 stated MD 1 gave the telephone order to discharge R6 and should have signed the telephone order but did not. e. A review of Resident 8's Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Physician and Telephone Orders, dated 7/15/19, indicated MD 2 gave a telephone order for the facility to discharge R 8 but did not indicate MD 2's signature. A review of R8's medical record and a concurrent interview with MDS1 on 4/14/2020 at 11 a.m., Section C of the MDS, dated [DATE], indicated R8's cognition was moderately impaired. MDS1 stated and confirmed R8 had moderately impaired cognition (characterized by ongoing memory problems such as confusion, attention problems, or language difficulties). During an interview, on 4/14/2020 at 4:56 p.m., LVN1 stated R8 was unable to care for herself and was receiving [MEDICAL TREATMENT] services during her stay at the SNF. LVN1 stated the physician should have ordered for the facility to arrange for R8 to receive [MEDICAL TREATMENT] services at a lower level of care facility. During an interview, on 4/13/2020 at 10 a.m., the Director of Nursing (DON) stated physicians were supposed to sign all of their telephone orders. During an interview with LVN 1, on 4/14/2020 at 4:56 p.m., LVN 1 stated MD 2 gave a the telephone order to discharge R8 and should have signed the telephone order but did not. During an interview with RN 1, on 4/14/20 at 5:05 p.m., RN 1 stated MD 1, MD 2 and MedDir 1 should have signed their telephone orders to discharge the residents but did not. During an interview with LVN 1, on 4/14/2020 at 5:10 p.m., LVN 1 stated MD 1, MD 2 and MedDir 1 should have signed their telephone orders to discharge the residents, but did not. On 4/14/2020 at 5:15 p.m., the Administrator stated the physicians should have signed their telephone orders to discharge the residents but did not. During an interview with MedDir 1 on 4/22/2020 at 1:42 p.m., MedDir 1 stated that physician's should sign the telephone orders that they give to the facility and when a doctor gives a telephone order to discharge a resident, the doctor was responsible for signing their telephone order even after the facility discharged the resident. During an interview, on 4/30/2020 at 9 a.m., MD 1 stated he did not remember giving the facility orders to discharge R1, R3 and R6 and that he did not sign the telephone orders to discharge R1, R3 and R6. A review of the facility's policy and procedures titled, Telephone Orders, revised 2/2014, indicated telephone orders must be countersigned by the physician during his or her next visit.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure five of eight sampled residents (Resident 1, R2, R3, R7 and R8) received medically-related social services to meet the resident's needs and attain or maintain their highest practicable well-being. These residents did not receive appropriate transitions of care services upon discharge from the facility. These deficient practices resulted in: -Resident 1 was discharged to an independent home that was not aware of the dementia [DIAGNOSES REDACTED]. -R2 stated he became so depressed when the facility dropped him off that he could not think enough to take his medications because he was so overwhelmed. R2 began to cry. -R3 recieved a physician's order for palliative services (care that improve the quality of life of patients with problems associated with life-threatening illness) but did not require palliative care services, as he was independent and had no life threatening illnesses. -R7 was discharged to an independent living facility which did not provide the services that R7 needed. -R8 was discharged to an independent home that did not know the resident required [MEDICAL TREATMENT] treatments. R8 subsequently did not receive [MEDICAL TREATMENT] treatments for a week and then required hospitalization . Findings: a. A review of Resident 1's (R1) medical record indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of R1's Initial History and Physical form, documented by Medical Doctor 1 (MD 1) dated [DATE], indicated R1 has fluctuating capacity to understand and make decisions. A review of the Physician and Telephone Orders, dated [DATE], indicated MD 1 gave a telephone order for the facility to discharge R1 but did not indicate MD 1's signature. MD 1 also ordered the facility to arrange for R1 to receive palliative care services (care that improve the quality of life of patients with problems associated with life-threatening illness) after discharge. During an interview, on [DATE] at 4:56 p.m., RN 1 stated that MD 1 ordered the facility to arrange for R1 to receive palliative care services after his discharge. b. A review of Resident 2's (R2) medical record indicated an admission to the skilled nursing facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Physician and Telephone Orders, dated [DATE], indicated MedDir 1 gave a telephone order for the facility to discharge R2 but did not indicate MedDir 1's signature. A review of another Physician and Telephone Orders, dated [DATE], indicated that MedDiR 1 ordered the facility to arrange for R2 to receive hospice services after his discharge. During an interview, on [DATE] at 4:56 p.m., Licensed vocational nurse 1 (LVN 1) stated and confirmed that R2 needed at least 20 medications a day at the time of his discharge. LVN 1 also stated R2 needed one-person-assist with most things, such as taking his medications, walking, showering, getting dressed, and getting in and out of bed, as indicated in the MDS. LVN 1 stated MedDiR 1 ordered the facility to arrange for R2 to receive hospice services after discharge. During an interview,on [DATE] at 1:30 p.m., R2 stated, I am legally disabled [MEDICAL CONDITION]. R2 stated the facility discharged him to a few blocks from a friend's house who had a trailer in his backyard. R2 stayed there to stay safe from COVID (Covid-19, a respiratory disease that has caused a worldwide pandemic that has killed many people). R2 stated the trailer had no air conditioning and was very hot during the day. R2 stated he walked with a cane, because he had difficulty walking and was unsteady on his feet and gets tired easily. R2 stated he must use a ridesharing program for transportation to the grocery, and when he goes to the grocery, he cannot buy much food because he cannot carry much food back to the trailer. R2 also stated he gets confused every few days and loses track of time, which he stated was, scary, because I know I can't figure out how to do something that I know I know how to do. R2 stated he had difficulty dressing because he could not bend over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	**831 S LAKE STREET LOS ANGELES, CA 90057**

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 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) well. R2 stated he loses track of time and therefore had difficulty knowing whether he took his medications and loses count when he was preparing the medications. R2 stated he must take [MEDICAL CONDITION] daily for them to be effective. R2 stated he was so depressed when the facility dropped him off that he could not think enough to take his medications because he was so overwhelmed. R2 began to cry and stated he enrolled himself in a hospice program (a service for those with terminal medical conditions that helps someone to die in a comfortable state of being). During an interview, on [DATE] at 3:15 p.m., Social Worker Assistant 1 (SWA1) stated the facility's Social Services department was responsible for arranging post-discharge services ordered by a physician. SWA1 stated Social Services should have arranged for R2 to receive palliative or hospice services, but did not. c. A review of Resident 3, and Resident 7's Physician and Telephone Orders, dated [DATE], indicated MD 1 ordered the facility to arrange for R3 and R7 to receive palliative care services after discharge. During an interview, on [DATE] at 4:56 p.m., LVN 1 stated MD 1 ordered the facility to arrange for R3 and R7 to receive palliative / hospice services after discharge. A review of R7s Section G of the MDS dated [DATE], and concurrent interview, on [DATE] at 11 a.m., indicated R7 needed assistance with transferring in and out of bed, dressing and personal hygiene; and needed extensive assistance with toileting, and bathing. MDS1 stated and confirmed that R7 needed assistance transferring in and out of bed, dressing and personal hygiene; and needed extensive assistance with toileting, and bathing. During an interview on [DATE] at 4:56 p.m., LVN1 stated R7 needed assistance with Grooming/Dressing, Bathing, Housekeeping, Shopping, Transportation to MD/Other, Therapy, Financial Management. LVN 1 stated R7 was not independent and used a wheelchair. During an interview on [DATE], at 3 p.m., Social Worker Assistant 1 (SWA1) stated she did not know R7 did not arrive at the independent living facility as planned. SWA1 stated she did not know that the independent living facility did not provide the services that R7 needed. During an interview, on [DATE] at 3:15 p.m., SWA1 stated the facility's Social Services department was responsible for arranging post-discharge services ordered by a physician. SWA1 stated Social Services should have arranged for R3 and R7 to receive palliative or hospice services, but did not. d. A review of Resident 8's (R8) Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of R8's Discharge/Transfer Transportation Safety Assessment, dated [DATE], indicated R8 was Unable to meet self-care needs. A review of the Physician and Telephone Orders, dated [DATE], indicated MD 2 ordered the facility to arrange for R8 to receive Home Health services (medical services and assistance provided in the setting outside of a skilled nursing facility, such as a patient's home) after the discharge. A review of R8's MDS dated [DATE], indicated R8 needed assistance with transferring in and out of bed, walking and personal hygiene and that R8 needed extensive assistance with toileting and bathing. During an interview with LVN 1 on [DATE] at 5:10 pm, LVN 1 stated the facility did not discharge R1, R2, R3 R7, and R8 correctly. LVN 1 stated that not discharging someone according to the regulations can be dangerous. During an interview, on [DATE] at 4:56 p.m., LVN1 stated R8 was unable to care for herself and was receiving [MEDICAL TREATMENT] services during her stay at the SNF. LVN1 stated R8 cannot take care of herself and the physician should have ordered for the facility to arrange for R8 to receive [MEDICAL TREATMENT] services at a lower level of care facility. LVN 1 stated MD 2 ordered the facility to arrange for R8 to receive home health services after her discharge. LVN 1 stated the facility should have arranged for R8 to continue receiving [MEDICAL TREATMENT] but did not; and that the facility should have conveyed to the independent living facility that R 8 required frequent [MEDICAL TREATMENT] but did not. During an interview with SWA 1 on [DATE] at 3:15 p.m., SWA 1 stated the facility's Social Services department was responsible for arranging post-discharge services ordered by a physician. SWA1 stated that Social Services should have arranged for R8 to receive [MEDICAL TREATMENT] services at the independent living facility and should have endorsed to the independent living facility that R8 required frequent [MEDICAL TREATMENT] but did not. A review of the medical record for R 8 indicated a document titled Emergency Department Encounter Note, written by MD 6, dated [DATE], indicated R8 did not have [MEDICAL TREATMENT] for five days after discharge from the facility to a lower level of care. The Noted indicated R8 suffered very high blood pressure, difficulty breathing, and required emergency [MEDICAL TREATMENT] and other treatments at a hospital. During an interview on [DATE] at 3 p.m., MD 6 stated had R8's conditions not been treated, R8 could have died as a result. A review of the facility policy and procedure titled, Activities and Social Services, indicated should a resident be considered to lack sufficient decision making capacity, mental incompetence, or physical capacity to participate in Social Service Programs. Social services staff will documnet the reasons for any limitations in the resident's medical record. The policy did not indicate, per federal regulation the facility will provide medically-related social services to meet the resident's needs and attain or maintain their highest practicable well-being, in addition, Social Services department was responsible for arranging post-discharge services ordered by a physician.