STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA PLAZA CONVALESCENT CENTER	**1209 HEMLOCK WAY SANTA ANA, CA 92707**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of two sampled residents (Resident 1) was safe to transfer to a lower level of care. Resident 1 was transferred and discharged to a room and board facility (a residential home not licensed to provide care and supervision to their residents, the residents are expected to manage their medication, transportation, and other needs on their own). The facility failed to ensure Resident 1 was assessed by the physician to determine whether the discharge was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet his health needs. This resulted in Resident 1 sustaining a fall, requiring hospitalization and readmission to the facility. Findings: Review of the facility's P&P titled Discharge and Transfer of Residents dated February 2018 showed a resident's discharge summary/post discharge plan will include documentation from the IDT regarding transfers or discharges, including the resident's discharge destination, including address and phone number, and the identity of specific community agencies and services to be provided. In addition, the medical record will contain documentation from the resident's attending physician regarding the resident's discharge plan of care if the resident is discharged because the resident's health has improved and he or she no longer needs the facility's services. Closed medical record review for Resident 1 was initiated on 4/29/2020. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's history and physical examination [REDACTED]. Review of the physician's orders [REDACTED]. Review of Resident 1's Assessment for Self-Administration of Medications dated 1/13/2020, showed Resident 1 did not wish to self-administer the medications. There was no additional assessment of Resident 1's ability to self-administer the medications was completed. Review of the Interdisciplinary Team Conference Record dated 1/15/2020, showed the purpose of the conference was to discuss Resident 1's admission. Resident 1 attended the conference. However, Resident 1's medical record failed to show any additional quarterly or discharge Interdisciplinary Team Conference Record. Review of Resident 1's plan of care showed a care plan problem dated 1/13/2020, to address the discharge planning. Resident 1 wanted to be discharged home or to a board and care facility (a residential home licensed to provide care and supervision to their residents). The approaches included to follow up with Resident 1 to assure understanding of the plan or answer additional questions, assist in decision making, and offer opportunity for the resident to visit potential new home or care center. Review of Resident 1's Discharge Planning assessment dated [DATE], showed Resident 1 preferred to be discharged back to his home. Review of Resident 1's Intervention Notes showed an entry by the SSD dated 3/18/2020 at 1530 hours, showing Resident 1 would remain in the facility pending assistance with placement due to Resident 1's inability to care for himself. Review of the Physician's Progress note dated 4/16/2020, showed Resident 1 was seen by the physician. The documentation showed Resident 1's assessment and plan included the following: to be reevaluated by psychiatry due to [MEDICAL CONDITION] disorder, thrush (fungal infection) on [MEDICATION NAME] (antifungal medication), and weight loss improving on diet. Review of Resident 1's medical record failed to show Resident 1 was assessed by the physician to determine whether Resident 1's transfer was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet Resident 1's needs. Review of the physician's telephone order dated 4/22/2020, showed for Resident 1 to be discharged on [DATE], to a room and board facility (Facility A) with home health services for medication management and physical therapy for safety evaluation and treatment. Review of Resident 1's Notice of Proposed Transfer and discharge date d 4/22/2020, signed by the facility representative on 4/23/2020, showed Resident 1's discharge was appropriate because his health had improved sufficiently and he had no longer required the services provided by the facility. The notice failed to show the address of Facility A. Review of Resident 1's Discharge Summary/Post Discharge Plan of Care signed by the IDT representative dated 4/23/2020, showed Resident 1 was incontinent of bowel and bladder and needed assistance with bathing, dressing, personal hygiene, transfers, bed mobility, toilet use, and ambulation. The discharge summary failed to show the name and contact information of the home health agency Resident 1 was to receive their services after discharge from the facility. On 5/1/2020 at 1303 hours, a telephone interview and concurrent closed medical record review was conducted with the SSD. The SSD was asked about the process for discharging or transferring of the residents. The SSD stated when a resident was admitted they began their discharge planning assessment to determine the resident's prior living arrangement. In addition, the resident was assessed weekly to determine how they were progressing and if they were ready to be discharged . The SSD stated a room and board facility was an independent living housing place where the residents must be able to dispense their own medications. When asked about Resident 1's discharge to a room and board facility (Facility A), the SSD stated she was not involved in Resident 1's discharge planning. The SSD was asked if she had assessed Resident 1's discharge plan prior to discharge. The SSD stated no. The SSD was asked if she had called Facility A to evaluate Resident 1. The SSD stated no. The SSD stated the Case Manager (CM) was in charge of Resident 1's discharge. On 5/1/2020 at 1333 hours and on 5/19/2020 at 1600 hours, a telephone interview and concurrent closed medical record review was conducted with the CM. The CM stated when a resident was admitted to the facility, they would meet with the resident and determine whether the resident would need a placement after discharge. The CM stated she would assess the resident's prior living situation and assess the resident's plan before the resident was discharged from the facility. The CM stated she was asked to assist with Resident 1's discharge planning on 3/19/2020. The CM was asked if she had conducted the initial call to Facility A to evaluate Resident 1. The CM stated no. The CM was asked if she had assessed, reviewed Resident 1's discharge, provided orientation or spoken to Resident 1 about his discharge. The CM stated no, because Facility A had already visited and evaluate Resident 1. On 5/1/2020 at 1512 hours, a telephone interview was conducted with the SSA. The SSA stated she was not involved in Resident 1's discharge planning. When asked if she called Facility A to refer Resident 1. The SSA stated no. When asked if the SSA had discussed with Resident 1 about discharging to Facility A, the SSA stated no. When asked if the SSA had relayed the information about Facility A to the CM, the SSA stated no. On 5/4/2020 at 1517 hours, a telephone interview was conducted with the Case Manager Assistant (CMA). The CMA stated she was responsible in assisting the resident's discharge planning. The CMA was asked if she had contacted Facility A regarding Resident 1. The CMA stated no. The CMA was asked if she was asked to assist the CM for Resident 1's discharge. The CMA stated no. The CMA was asked if she had discussed the discharge plan with Resident 1. The CMA stated no. On 5/12/2020 at 1155 hours, a telephone interview was conducted with the owner of Facility A. The owner of Facility A was asked what type of services they provided. The owner stated they provided a room, laundry services, meals, safety, and activities for the residents. The owner added they did not have licensed staff to administer residents' medications. The owner stated the residents who

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.

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F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resided in their facility were independent residents who could care for themselves. The owner stated when Resident 1 arrived to Facility A, Resident 1 got anxious and repeatedly stated he wanted to return to the skilled nursing facility, ran out of the house, fell , and was sent to the acute care hospital Emergency Department. On 5/19/2020 at 1543 hours, a telephone interview was conducted with the LVN. LVN 1 stated she was responsible for the discharge of Resident 1. LVN 1 stated Resident 1 was very quiet while she reviewed the discharge summary with him. LVN 1 stated when she told Resident 1 the staff from Facility A were at the facility to pick him up, Resident 1 went to sleep and did not want to wake up. LVN 1 added the other nurses on the shift informed her Resident 1 always wanted to leave but did not say where he wanted to go. LVN 1 was asked about Resident 1's discharge instructions. LVN 1 verified the home health agency's contact information was not provided on Resident 1's discharge summary. On 5/22/2020 at 1404 hours, a telephone interview was conducted with the DON. The DON was asked about the discharge process. The DON stated on admission, the CM and the social services staff would meet with the resident and assess the resident's discharge needs, then IDT would meet to assess each resident's discharge plan on admission. The DON added when the rehabilitation department staff discharged the resident, they would conduct a discharge IDT meeting to determine the appropriate placement for the resident. The DON stated the social services staff and CM would be the one responsible for arranging the residents' discharge. Once the discharge had been arranged, the DON stated the social services staff or CM would notify the licensed nurse who would then call the physician to determine whether the resident may discharge with arrangements. The licensed nurse would fill out the discharge summary sheet and consult with the social services or CM for any additional information to share with the resident. The DON stated on the discharge day, the licensed nurse was to verify all discharge instructions were complete and to provide the information to the resident on the day of discharge. The DON was asked about Resident 1's discharge. The DON stated Resident 1 was admitted with depression and was in the facility for medication management and rehabilitation. The DON stated Resident 1 was supposed to be discharged a month earlier but had to wait for his social security checks. When asked if she was aware if Resident 1 was involved in choosing and consented in going to Facility A. The DON stated she did not know and added it was the social services and case management staff's responsibility. When asked about Resident 1's wanderguard, the DON stated when Resident 1 was admitted , he had a history of [REDACTED]. When asked if Resident 1 had ever attempted to leave while at the facility. The DON stated no. The DON stated the wanderguard was used for safety. When asked if the nurses had assessed Resident 1 to determine if placing him at Facility A was appropriate with the behavior of running in the hallways. The DON stated the licensed nurses were supposed to discontinue the wanderguard. When asked if Resident 1 was assessed to determine whether he was able to self-administer his own medications, the DON stated she did not know. The DON added she did not know what services a room and board facility provided. The DON stated they were supposed to hold a discharge IDT meeting prior to Resident 1's discharge; however, the DON verified they did not have documentation of their meeting. The DON verified Resident 1's discharge orders were to go home with home health services and verified the information was not provided to Resident 1. The DON verified Resident 1's physician did not document a discharge assessment was completed prior to Resident 1's discharge.