STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555231	A. BUILDING _____ B. WING _____	**06/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TAHOE FOREST HOSPITAL D/P SNF	**10121 PINE AVE. TRUCKEE, CA 96160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect one of two sampled residents (Resident 2) from physical abuse, when Resident 1 punched Resident 2 in the back. This failure resulted in emotional distress and had the potential to cause pain and suffering resulting in potential adverse clinical outcomes. Findings: A review of Resident 2's Progress Note (PN) dated 4/08/20, indicated, she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Transfer Summary (TS) dated 4/22/20 indicated he was admitted to the facility on [DATE] [DIAGNOSES REDACTED]. He also has additional problems with coordination. The assessment indicated, Long-term care admission for custodial care due to cognitive and memory deficits. The facility's policy titled, ECC Abuse Prevention of, dated 5/2020, was reviewed and indicated that each resident has the right to be free from verbal, sexual, physical and mental abuse. All residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers. During a review of Resident 1's Interdisciplinary Team (IDT) notes, dated February, March, and April 2020 indicated, seven out of 29 days in February 28 out of 31 days in March, and on April 19th, Resident 1 will remain separated from Resident 2. During a concurrent interview and record review on 4/22/20 at 11:36 a.m., with Director of Nurses (DON), Resident 1's Interdisciplinary Progress Note (IDT, a team that works together to provide the greatest benefit for the Resident) dated 4/19/20 at 07:34 a.m., was reviewed. The IDT note indicated Resident 1 and Resident 2 were in the dining room together alone and Resident 2 punched Resident 1 in the back. DON confirmed they should not have been in the dining room alone. During an interview on 4/22/20 at 1:15 p.m., the Social Services Director (SSD) stated, the care plans are part of their IDT progress notes. In the IDT progress notes they chart the problems, goals and plans. During a concurrent interview and record review on 4/23/20 at 2:44 p.m., with Certified Nurse Assistant (CNA) B, Resident 1's facility's report dated 4/4/20 at 6:28 p.m., was reviewed. The facility's report indicated, on 4/4/20 at 6:28 p.m., Resident 2 came out of dining room yelling and crying, he punched me in the back! CNA B confirmed, Resident 1 and Resident 2 were in the dining room alone and they should not have been. During a concurrent interview and record review on 4/22/20, at 2:00 p.m., with the MD, Resident 1's Care Plan Conference (CPC) was reviewed, the CPC indicated, Resident 1 had physically abused Resident 2 on 12/14/19, 2/23/20 in the dining room and 4/19/20 in the hall way in front of the dining room. MD confirmed Resident 1 should not be left alone with Resident 2. During an interview on 5/13/20 at 9:00 a.m., with CNA C, CNA C stated, we are not able to be with them all the time due to not enough staff. We try to keep a watch out for Resident 2 when she is out of her room but, sometimes they were all busy helping other residents and things got missed. CNA C confirmed she was not told Resident 1 and Resident 2 could not be in hall or dining room alone together. During an interview on 5/13/20 at 11:30 a.m., with Resident 2, Resident 2 stated, I was leaving the dining room and Resident 1 punched me in the back. Resident 2 also stated, Resident 1 is always mean to me whenever I pass him in the hallway or dining room. During an interview on 5/13/20 at 2:10 p.m., with Activities Assistant (AA), AA stated, she was unaware the Resident 1 and Resident 2 had to be kept separate when they were out of their rooms. AA also stated Resident 1 and Resident 2 went around the facility independently and it seemed Resident 2 would physically abuse Resident 1 when no one was around. AA confirmed Resident 1 has been physically abused by Resident 2 multiple times. During an interview on 5/19/20 at 1:22 p.m., with CNA D, CNA D stated, she was never told Resident 1 and Resident 2 had to be away from each other while in the hall way and dining room. CNA D also stated when we would go into the dining room in the afternoons and help when we could, but it was impossible to watch them all the time. During an interview on 5/13/20 at 1:32 p.m., with Registered Nurse (RN) A, RN A stated they were not able to keep an eye on Resident 1 or Resident 2 all the time. RN A stated the altercations seem to happen in the hall when no one is around. RN A confirmed she was not told Resident 1 and Resident 2 could not be in the hall way by themselves. During a review of Resident 1's Care Team Notes (CT), dated 3/4/20, the CT indicated, the facility will implement interventions: 1. To reduce triggers: CNA B will not provide care for either Resident 1 or Resident 3. 2. Staff will continue to round and monitor to minimize interactions with trigger situations or people.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Resident 1's Family Member (FM) 1 with a written notice of bed hold before Resident 1 was transferred to a local acute care hospital that explained the duration of the bed hold and addressed permitting the return of the resident to the first available bed. This failure resulted in the Resident 1's representative to not know Resident 1's right of being allowed to return to the facility when discharged from the emergency room . Findings: A review of Resident 1's Transfer Summary (TS) dated 4/22/20 indicated he was admitted to the facility on [DATE] [DIAGNOSES REDACTED]. He also has additional problems with coordination. The assessment indicated, Long-term care admission for custodial care due to cognitive and memory deficits. The facility's BIMS test (a Brief Interview for Mental Status that is used to get a quick snapshot of how well a resident is functioning cognitively), dated 3/10/20, indicated Resident 1 had a BIMS score of 4 indicating his cognition was severely impaired. An Interdisciplinary Team Progress Note (IDT) dated 4/20/20 at 7:09 am was reviewed. According to the documentation, Night shift Certified Nurse Assistant (CNA) was assisting Resident 3 in getting up, Resident 1 was out of the room filing water cups. Assistance was required with initial transfer and Day CNA came in to help. Resident 1 returned to the room during the transfer, was agitated and used bad language, set down water cups and elbowed CNA in the back. Director of Nurses (DON) notified, decision made to transfer resident to emergency room (ER) for further evaluation, security and nursing supervisors escorted without incident. Verbal report given to ER nurses along with paper chart. An IDT Note dated 4/20/20 at 10:30 am indicated Resident 1 and 3's Representative is here to see Residents 1 and 3 at window and would like to drop off some mints. Met FM 1 outside facility with Registered Nurse (RN) Supervisor. Took mints for Resident 3 and told FM 1 that Resident 1 was not in our facility anymore and he was transferred to the ER (emergency room) this morning for striking a staff member. FM 1 was advised to visit with Resident 3 at window and then go to ER and check on situation there. The facility's policy and procedure (P&P) titled, ECC Bed-hold, dated 5/2020, was reviewed. It indicated, It is the policy of this facility to notify resident and family members or legal representative the duration of the bed hold period when a resident requires transfer to a hospital or a therapeutic leave. At the time of transfer out to acute stay notice of transfer or discharge form completed. One copy to chart, one copy to resident/resident representative and one faxed to local ombudsman. In case of emergency, notice can be given within 24 hours. During a review of Resident 1's clinical record

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dated April and May 2020, there was no documentation found regarding written notification to FM 1 for the bed-hold. During an interview on 4/22/20 at 10:00 a.m., with FM 1 and the Ombudsman (an official, usually appointed by the government, who advocates on behalf of their residents), they confirmed they did not receive a copy of the written notification from the facility regarding the bed-hold, or refusal to readmit Resident 1. Resident 1's Representative stated they were very upset that the facility was refusing to readmit Resident 1.
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, The facility failed to permit Resident 1 to return to the facility, during the bed-hold period and after a discharge appealed was granted, for care and services after discharge to the emergency room (ER) by the facility for evaluation due to being combative and refusing care. These failures violated Resident 1's rights to return to the facility where a family member is a resident and resulted in Resident 1's prolonged hospitalization in a local General Acute Care Hospital since 4/20/20. Findings: The clinical record for Resident 1 was reviewed and indicated that Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A document titled History & Physical dated 2/13/20 and a document titled Progress Note dated 3/11/20, both indicated that resident 1 was admitted for , Long-term care admission for custodial care due to cognitive and memory deficits. The facility's Brief Interview for Mental Status test (BIMS used to get a quick summary of a resident's immediate cognitive functioning) dated 3/10/20 indicated Resident 1 had a BIMS score of four indicating his cognition was severely impaired. The facility's policy and procedure titled, ECC Bed-hold, dated 05/2020, was reviewed and indicated under the heading Policy - It is the policy of this facility to notify resident and family members or legal representative the duration of the bed hold period when a resident requires transfer to a hospital or a therapeutic leave. Under the heading Procedure the policy further indicated, At the time of Transfer . one copy to resident/resident representative and one faxed to local ombudsman. In case of emergency, notice can be given within 24 hours. The facility is required to permit residents to return to the facility immediately to the first available bed. In the event that the resident does not return by the seventh day, the resident is officially discharged The resident may be readmitted , if they desire, upon the first bed availability. The facility's policy and procedure titled, ECC Transfers and Discharges dated 06/2020, was reviewed and indicated under the heading Policy - Transfer is moving the resident from the facility to another legally responsible institution setting, while discharge is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care. Under the heading Procedure the policy indicated, The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility A report titled Refusal to Readmit Appeal dated 5/15/20 indicated that the facility must immediately offer to readmit Resident 1 to his former bed Should Resident's former bed be unavailable, the facility shall offer resident readmission to the first available male bed. The clinical record for Resident 1 was reviewed. An Interdisciplinary Progress Note, dated 4/20/20 at 7:09 am, indicated that a Night shift Certified Nurse Assistant (CNA) E was assisting Resident 3 in getting up. Resident 1 was out of the room filling water cups. CNA E required assistance with the initial transfer of Resident 3 and CNA B came in to help. Resident 1 returned to the room while the two CNAs were transferring Resident 3 to a wheelchair and was agitated and used bad language. Resident 1 set down the water cups and elbowed CNA in the back. The Director of Nurses (DON) was notified and a decision made to transfer Resident 1 to the emergency room (ER) for further evaluation, security and nursing supervisors escorted Resident 1 to the ER without incident. A Verbal report was given to ER nurses along with the paper chart. The clinical record for Resident 1 was reviewed. An Interdisciplinary Progress (IDT) Note, dated 4/20/20 at 10:30 am, indicated that Family Member (FM) 1 was told that Resident 1 was no longer in the facility and that he was transferred to the ER (emergency room) this morning for striking a staff member. FM 1 was advised check on situation at the ER. During an interview on 4/22/20, at 10:00 am, FM 1 stated, that he was upset the ER at Local General Acute Care Hospital called him up and told him Resident 1 was being discharged and he needed to come pick him up from the ER. FM 1 refused to pick Resident 1 up and told them (the ER) he was unable to take care of Resident 1 at home. FM 1 stated that due to his traveling for work, it would not be safe for Resident 1 to be there. FM 1 also voiced his concerns regarding separating Resident 1 and a family member that was also a resident at the facility. FM 1 did not want to separate them after [AGE] years of marriage; three of those years living at the facility together and that he wanted Resident 1 to go back. When the facility told FM 1, that Resident 1 could not come back FM 1 was very upset and did not understand why, Out of the blue the facility would do this. FM 1 was also upset because the facility wanted him to pick up Resident 1 without there being a safe plan in place and FM 1 stated, How can they do that? FM 1 stated that he found out Resident 1 had been transferred when he came to see Resident 1 and bring him snacks. That was when the facility informed him that Resident 1 was transferred to the hospital the day before. FM 1 stated that his the other family member living in the facility with Resident 1 had called him up crying, stating the facility had packed all Resident 1's things up and sent them to the hospital with Resident 1. During an interview on 04/22/20 at 10:00 am, Family Member (FM) 1 and the Ombudsman (an official, usually appointed by the government, who advocates on behalf of residents) confirmed that the facility had informed them (FM 1 and Ombudsman) that they (the facility) had given Resident 1 a 30-day notice. FM 1 and the Ombudsman stated that they had never received a copy of the written notification from the facility regarding the bed-hold, or refusal to readmit Resident 1. FM 1 stated he was very upset that the facility was refusing to readmit Resident 1. During a concurrent interview and record review on 04/22/20, at 11:36 a.m., with Director of Nursing (DON), Resident 1's IDT was reviewed. The IDT indicated that the DON informed the Ombudsman and FM 1 they were not readmitting Resident 1 back to the facility. The DON confirmed that Resident 1 had been discharged to the emergency room and the facility was allowing him to return. During an interview on 04/22/20, at 1:15 pm, the Social Services Director (SSD) stated that Resident 1 was discharged and he is not coming back, and we informed the FM 1 when he came to see Resident 3. SSD confirmed the facility packed up all Resident 1's belongings and were not going to readmit Resident 1 back in to the facility. The clinical record for Resident 1 was reviewed. A document titled, Transfer Summery (TS), dated 04/22/20, was reviewed. The TS indicated, that FM 1 was informed that Resident 1 was transferred to the emergency room and would not be able to return to the Skilled Nursing Facility, other arrangements for placement would be pursued. Further care would be provided by the staff at the local General Acute Care Hospital and placement to another facility would be determined at a future date. During a concurrent interview on 04/24/20, at 2:00 pm, the facility's Medical Doctor confirmed that there was no discharge plan in place for Resident 1. During an interview on 05/13/20, at 12:10 pm, CNA C stated that the facility had packed up all of Resident 1's belongings and told us he (Resident 1) was not coming back. During an interview on 5/16/20, at 7:00 am, FM 1 stated, he had won the discharge appeal however, the facility still refused to readmit Resident 1 back to the facility. The facility failed to permit Resident 1 to return to the facility for care and services after discharge to the emergency room (ER) for evaluation due to being combative and refusing care. This failure violated Resident 1's right to return to the facility where a family member is a resident and resulted in Resident 1's prolonged hospitalization in a local General Acute Care Hospital since 4/20/20. This violation caused or occurred under circumstances likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to a patient.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement Resident 1's care plan that directed staff to monitor Residents 1 and Resident 2 to keep them apart, and to prevent CNA B from caring for Resident 1 because CNA B triggered resident 1's bad behavior. These failures resulted in Resident 1 physically abusing resident 2 and put CNA B at risk for injury. Findings: A review of Resident 1's clinical record indicated he was originally admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set (MDS, an assessment tool), dated 3/10/20, indicated Resident 1's Brief Interview for Mental Status was 4, indicating he had severe cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 required Long-term care admission for custodial care due to cognitive

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) and memory deficits. A review of Resident 1's Transfer Summary (TS) dated 04/22/20 indicated he was admitted to the facility on [DATE] [DIAGNOSES REDACTED]. He also has additional problems with coordination. The assessment indicated, Long-term care admission for custodial care due to cognitive and memory deficits. During a review of Resident 1's Interdisciplinary Progress Notes (IDT), dated 2/24/20, the IDT Notes indicated, the goal for Resident 1 is to remain separated from Resident 2. During a review of the facility's policy and procedure (P&P) titled, Nursing Admit Assessment-reassessment and Documentation, DECC-010, dated 2020, the P&P indicated, the care plan should be finalized in accordance with the Resident Assessment Instrument (RAI) Resident Assessment Instrument (RAI) (a tool that helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan). The RAI indicated, facilities are responsible for assessing and addressing all care issues, including monitoring each resident's condition and responding with appropriate interventions. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. During an interview on 04/22/20 at 1:15 p.m., with Social Services Director (SSD), SSD stated, stated, the care plans are part of their Interdisciplinary Progress Notes (IDT) progress notes. In the IDT progress notes they chart the problem, goal and plan. During a concurrent interview and record review, on 4/22/20 at 11:33 a.m., with Director of Nursing (DON), Resident 1's Care Team Notes (CTN) dated March 4, 2020 was reviewed. The CTN indicated, the facility was supposed to implement several interventions: to reduce triggers: 1) Certified Nurse Assistant (CNA) B will not provide care for either Resident 1 or his spouse, 2) have a written plan in place in case of another aggressive incident and staff will continue to round and monitor to minimize interactions with trigger people or situations. DON confirmed CNA B was supposed to be removed from providing care for Resident 1. During a concurrent interview and record review, on 4/24/20, at 2:00 p.m., with the Medical Doctor (MD), Resident 1's History and Physical (H&P), dated April 2020 was reviewed. The H&P indicated, the facility was to remove staff members from providing care to him, members that he disliked or became aggressive with. MD confirmed CNA B was a trigger for Resident 1. During an interview on 4/28/20, at 2:44 p.m., with Certified Nurse Assistant (CNA) B, CNA B stated, I was never told not go into Resident 1's room. CNA B also said she was not aware that at the care conference the facility told Resident 1's son that she would not go in the room. During an interview on 5/13/20, at 12:10 p.m., with CNA C, CNA C stated, we are not able to be with Resident 1 all the time and sometimes things get missed, for example, when they pass each other in the hall way. CNA C confirmed that they were not told they needed to keep Resident 1 separated from Resident 2 when they were in the hall way at the same time. During an interview on 5/13/20, at 1:32 p.m., with Registered Nurse (RN) A, RN A stated, Resident 1 was independent and roamed the hall ways whenever he wanted. Due to his independence they were not able to watch him all the time. During an interview on 5/13/20, at 2:10 p.m., with the Activities Assistant (AA), AA stated, she was not aware Resident 1 needed to be kept separated from Resident 2 when they were going to and from the dining room per his care plan. AA confirmed Resident 1 and Resident 2 were found in the dining room on several different occasions alone. AA said Resident 2 is often going up and down the hall way in front of Resident 1's room unsupervised. During an interview on 5/19/20, at 1:22 p.m., with CNA D, CNA D stated, every morning her and CNA B would team up together to get residents up for breakfast, including Resident 1 and his spouse. CNA D confirmed she was never told CNA B could not help her. During a review of Resident 1's IDT, dated February, March, and April 2020 indicated, seven out of 29 days in February 28 out of 31 days in March, and in April 19th, Resident 1 will remain separated from Resident 2. During a review of Resident 1's IDT Notes, dated February 12, 2020, the IDT Notes indicated, CNA B has removed herself from caring for his or his spouse. When she is assigned to the team with that room, she trades with another team member and cares for different resident room. During a review of Resident 1's Plan of Care (PC), dated February 23,2020, the PC indicated, Resident 1 will be monitored in activities and while Resident 2 is present and completing her usual tasks of choice.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility discharged Resident 1 to the hospital's emergency room without developing and implementing an effective and safe discharge plan to ensure a smooth and safe discharge to a facility that met Resident 1's needs for long term care placement. This failure resulted in Resident 1 being discharged to an emergency room for a prolonged hospitalization , since 4/20/20, in which no arrangements for permanent placement had been developed. Findings: A review of Resident 1's clinical record indicated he was originally admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. The assessment indicated, Long-term care admission for custodial care due to cognitive and memory deficits. A review of the facility's Minimum Data Set (MDS, an assessment tool), dated 3/10/20, indicated Resident 1's Brief Interview for Mental Status was 4, indicating he had severe cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). During a concurrent interview and record review, on 4/24/20, at 2:00 p.m., with Medical Doctor (MD), Resident 1's Transfer Summery (TS), dated 4/22/20 was reviewed. The TS indicated, Family Member (FM) 1 was informed that Resident 1 was transferred to the emergency room and would not be able to return to the Skilled Nursing Facility other arrangements for placement would be pursued. Further care will be provided by the staff at the local hospital and placement to another facility will be determined at a future date. MD confirmed there was no discharge plan in place for Resident 1. During an interview on 4/22/20, at 10:00 a.m., with FM 1, FM 1 stated, the facility discharged Resident 1 without a plan or place for him to go to, so they sent him to the emergency room at the local hospital. During a concurrent interview and record review on 4/22/20, at 11:36 a.m., with Director of Nursing (DON), Resident 1's clinical record was reviewed. The clinical record did not have a safe discharge plan in place for Resident 1. DON confirmed there was no discharge plan. During an interview on 4/22/20, at 1:15 pm, with the Social Services Director (SSD), SSD stated, we discharged Resident 1, he is not coming back, and we informed FM 1 when he came to see Resident 3. SSD confirmed the facility packed up all his belongings and were not going to readmit Resident 1. During a phone interview on 4/24/20, at 2:40 p.m., with the Clinical Nursing Officer (CNO), the CNO stated, there was no documentation in the clinical record, of a safe and effective discharge plan in place for Resident 1. During an interview on 5/13/20, at 12:10 p.m., with Certified Nurse Assistant (CNA) C, CNA C stated, the facility packed all his stuff up and told us he was not coming back. During a review of Resident 1's MDS Section Q0400, dated 04/20/20, the MDS indicated, Resident 1 did not have an active discharge plan in place.