STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PASADENA CARE CENTER, LLC	**1640 N. FAIR OAKS AVENUE PASADENA, CA 91103**

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 provide in advance, a Notice of Proposed Transfer/Discharge and send a copy of the notice to a representative of the Office of the Long-Term Care (LTC) Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities) before discharging one of one sampled resident (Resident 1) to an Independent Living Facility 1 (ILF 1, any housing arrangement designed exclusively for older adults who need little or no assistance with activities of daily living, most do not offer medical care or nursing staff). This deficient practice resulted in the LTC Ombudsman's Office inability to advocate for and protect Resident 1 from improper and unsafe discharge. Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 9/30/19, indicated Resident 1 had the ability to communicate and had moderately impaired cognition (mental processing). The MDS indicated Resident 1 required supervision with bed mobility, transfer, locomotion on and off unit, eating, toilet use and personal hygiene, limited assistance with dressing, and required one-person physical help with bathing. The MDS indicated Resident 1 used a wheelchair for mobility and was occasionally incontinent of bowel and bladder. The MDS indicated the resident did not have an active discharge planning occurring to return to the community. A review of the Social Service assessment dated [DATE] indicated Resident 1 as self-responsible, alert to self with period of confusion and able to make needs known. The social service assessment indicated Resident 1 needed assistance with activities of daily living (ADLs), and a discharge plan for Resident 1 to stay long-term. The social service assessment indicated Resident 1 receiving [MEDICATION NAME] (medication for depression) 25 milligrams (mg, unit of measurement) for [MEDICAL CONDITION]. The social service assessment indicated Resident 1 was a widow and has a family member with mental disability who lives in a home. A review of the Interdisciplinary Team (IDT, involving two or more academic, scientific, or artistic disciplines) Care Conference Notes dated 10/22/19, indicated Resident 1 was alert with periods of confusion, verbally responsive and wheelchair bound. The notes indicated Resident 1 was a long-term care resident and was stable. A review of the physician's orders [REDACTED]. A review of the MDS dated [DATE] indicated the facility discharged Resident 1 to the community (private home/apartment, board/care, assisted living, group home) on 11/14/19, and return not anticipated. The MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 required supervision with bed mobility, transfer, locomotion on and off unit, eating, toilet use and personal hygiene and required one-person physical help with bathing. The MDS indicated Resident 1 required one person physical assist with dressing and occasionally incontinent of bowel and bladder. Section GG of the MDS did not indicate Resident 1's discharge performance functional abilities and goals or the resident's means of mobility. A review of Physician's Discharge Summary dated 11/14/19, timed 9:30 a.m., indicated a registered nurse (RN) noted Resident 1 as discharged to ILF 1 in a private care, ambulating (walking) and in stable condition. A Licensed Vocational Nurse 1 (LVN 1) electronically signed (E-Signed) the physician's discharge summary on 11/15/19 and a physician signed on 11/19/19. A review of the Social Services Notes dated 11/14/19, timed at 11:54 a.m., indicated Staff 1, an unnamed Residential Care Facility for the Elderly (RCFE, provides room, board, housekeeping, supervision, and personal care assistance with basic activities of daily living), assessed Resident 1 on 11/13/19. The notes indicated Resident 1 was discharged today (11/14/19) and picked up by Staff 1 on 11/14/19 at 9:30 a.m. A review of the Notice of Proposed Transfer/Discharge signed by an LVN on 11/15/19, indicated the facility sent a copy proposed discharge to the Ombudsman and Resident 1/Representative on 11/14/19. The notice indicated Resident 1 signed the Notice of Proposed Transfer/Discharge on 11/15/19. The notice indicated Resident 1's health had improved sufficiently and no longer needed the services provided by SNF 1 as the reason for discharge. The facility typed Resident 1's name on section for resident/representative signature dated 11/14/19. LVN 1 E-Signed the notice on 11/15/19. During an interview on 4/7/20 at 12:50 p.m., the local LTC Ombudsman stated the office did not receive a copy of the Notice of Proposed Transfer/Discharge from SNF 1 for Resident 1. During an interview on 4/7/20 at 8:57 a.m., the Administrator stated that he reviewed Resident 1's clinical records with the Medical Records Director and could not find documented evidence that a Notice of Proposed Transfer/Discharge was provided to Resident 1 and a copy of the notice was sent to the LTC Ombudsman's Office before Resident 1 was discharged from a Skilled Nursing Home 1 (SNF 1). A review of the facility's policy and procedures titled, Transfer or Discharge Notice, dated 7/2015, indicated the facility shall provide a resident and/or the resident's representative (sponsor) with a 30-day written notice of an impending transfer or discharge. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge. 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. The policy indicated a copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. Cross Reference F660
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 failed to develop and implement an effective discharge plan that addressed the safety, medication management, and activities of daily living (ADLs) needs prior to discharge for one of one resident (Resident 1). This deficient practice resulted in Resident 1's discharge to an Independent Living Facility 1 (ILF 1 - any housing arrangement designed exclusively for older adults who need little or no assistance with activities of daily living, most do not offer medical care or nursing staff) which was not approriate for the resident, without medications, prescription, and/or a post-discharge plan of care. Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Self Administration of Medication assessment dated [DATE], indicated the resident was not a candidate for safe self-administartion medications, was not alert and oriented to person, and did not want to self-administer medications. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 9/30/19, indicated Resident 1 had the ability to communicate and had moderately impaired cognition (mental processing). The MDS indicated Resident 1 required supervision with bed mobility, transfer, locomotion on and off unit, eating, toilet use and personal hygiene, limited assistance with dressing, and required one-person physical help with bathing. The MDS indicated Resident 1 used a wheelchair for mobility and was occasionally incontinent of bowel and bladder. The MDS indicated the resident did not have an active discharge planning occurring to return to the community. A review of the Social Service assessment dated [DATE] indicated Resident 1 as self-responsible, alert to self with period of confusion and able to make needs known. The social service assessment indicated Resident 1's discharge plan is to stay long-term, needs assistance with ADLs, and needs 24-hours nursing care. The social service assessment indicated Resident 1 was receiving [MEDICATION NAME] (medication for depression) 25

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 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) milligrams (mg, measuring unit) for [MEDICAL CONDITION]. The social service assessment indicated Resident 1 was a widow and has a family member with mental disability who lives in a home. A review of the Interdisciplinary Team (IDT, involving two or more academic, scientific, or artistic disciplines) Care Conference Notes dated 10/22/19, indicated Resident 1 was alert with periods of confusion, verbally responsive and wheelchair bound. The notes indicated Resident 1 was a long-term care resident and was stable. A review of the physician's orders [REDACTED]. The order did not indicate to discharge the resident with any medication. A review of the MDS dated [DATE] indicated the facility discharged Resident 1 to the community (private home/apartment, board/care, assisted living, group home) on 11/14/19, and return was not anticipated. The MDS indicated Resident had severe cognitive impairment. The MDS indicated Resident 1 required supervision with bed mobility, transfer, locomotion on and off unit, eating, toilet use and personal hygiene and required one-person physical help with bathing. The MDS indicated Resident 1 required one-person physical assist with dressing and occasionally incontinent of bowel and bladder. Section GG of the MDS did not indicate Resident 1's discharge performance functional abilities and goals or the resident's means of mobility. A review of Resident 1's Medication Administration Record [REDACTED]. Donepazil HCI (medication for dementia) tablet (tab) 5 mg mouth (po) at bedtime 2. [MEDICATION NAME] (appetite stimulant) oral suspension 40 mg per milliliter (ml, measuring unit), 10 ml po one time a day for decreased appetite 3. Multivital (multivitamins-minerals) tablet 1 tab po one time a day 4. Prevastatin Sodium (medication for [MEDICAL CONDITION]) 1 tab po at bedtime 5. [MEDICATION NAME] (medication to treat [MEDICAL CONDITION]) 75 micrograms (mcg, measuring unit) 1 tab po one time a day 6. Cranberry (supplement) 450 mg 1 tab po twice a day for urinary tract infection [MEDICAL CONDITION] (prevention) 7. [MEDICATION NAME] (medication for dementia) 10 mg 1 tab po twice a day The MAR indicated [REDACTED]. A review of Resident 1's Discharge Summary Comprehensive assessment dated [DATE], indicated the resident as alert, oriented and confused at times and continent of bladder and bowel. The discharge summary indicated Resident 1 ate, performed personal hygiene, transfered, used the toilet, ambulated and mobilized independently. The summary indicated Resident 1's rehab/discharge as good. A review of Resident 1's Post (after) Discharge Plan of Care dated 11/14/19, indicated the facility developed the post discharge plan with the resident and other person (not specified). The post dischrarge plan of care did not indicate if the resident needed and/or if the facility sent the resident with equipment such as a commode, wheelchair, walker, cane or special bed. The post discharge plan of care indicated special training/instructions on how to take blood pressure and pulse (HR). However, the plan did not indicate who, when and how to record the blood pressure and pulse, when and what to report to the physician. The plan did not indicate if Resident 1 and other person understood the instructions or that they had equipment to record blood pressure and pulse. Medications that included cranberry, donepazil, [MEDICATION NAME], tylenol extra strength (mild pain medication), and [MEDICATION NAME] (medication for nausea), which were in non-child proof containers, were given to Resident 1. The post discharge plan of care indicated the resident/repsonsible party accepted the post discharge plan of care on 11/14/19. A review of Resident 1's Physician's Discharge Summary dated 11/14/19, timed 9:30 a.m., indicated a Registered Nurse (RN) documented that Resident 1 was discharged to ILF 1 in a private car and was ambulating (walking) and in a stable condition. A Licensed Vocational Nurse 1 (LVN 1) electronically signed (E-Signed) the physician's discharge summary on 11/15/19 and a physician signed on 11/19/19. The physician documented Resident 1's prognosis (likely outcome of a situation) as fair. A review of the Social Services Notes dated 11/14/19, timed at 11:54 a.m., indicated Staff 1 from an unknown Residential Care Facility for the Elderly (RCFE, provides room, board, housekeeping, supervision, and personal care assistance with basic activities of daily living), assessed Resident 1 on 11/13/19. The notes indicated Resident 1 was discharged on [DATE] and picked up by Staff 1 on 11/14/19 at 9:30 a.m. A review of the Notice of Proposed Transfer/discharge date d 11/15/19, indicated the facility notified Resident 1 of proposed discharge to ILF 1 that same day, on 11/14/19. The notice indicated Resident 1's health improved sufficiently and no longer needed the services provided by the facility. A review of the Social Services Notes dated 11/20/19, timed at 9:03 a.m., indicated the Social Services Director 1 (SSD 1) contacted ILF 1 to follow up on Resident 1. The note indicated Staff 1 informed SSD 1 that Resident 1 was not at RCFE. During a telephone interview on 3/26/20 at 10 a.m., the facility's Medical Records Director (MRD) stated she reviewed Resident 1's clinical records and that there was no documentation of a post-discharge plan of care. During a telephone interview on 4/7/20 at 8:57 a.m., the Administrator stated he was not familiar with Resident 1's discharge planning. The Administrator stated SSD 1 and interim Director of Nursing (DON) at the time of Resident 1's discharge no longer worked for the facility. During a telephone interview on 4/7/20 at 9:49 a.m., Resident 1's Attending Physician (Physician 1) stated Resident 1 had a [DIAGNOSES REDACTED]. Physician 1 stated Resident 1 is a long-term custodial care (refers to services ordinarily provided by non-licensed caregivers) resident. Physician 1 stated I don't think so. I don't have that in my record when asked if he gave the order to discharge Resident 1 to ILF 1. During a telephone interview on 4/8/20 at 9:12 a.m., SSD 2 stated a resident must be medically stable, ambulatory, able to do things on his/her own, alert and oriented, have the capacity to make decisions and a steady income to ensure a safe discharge before discharged to an independent living facility. A review of the facility's policy and procedure titled, Discharge Medications, revised 1/15, indicated a physician must be contacted for an order to discharge a resident with medications before dispensed. A review of the facility's policy and procedures titled Discharge Plan and Post Discharge Plan of Care dated 1/2015, indicated the Discharge Planning Coordinator with consultation from the Interdisciplinary Team (IDT), shall provide a discharge planning service and process for each resident admitted , that identifies and evaluates the resident's needs and assists him/her in moving from one environment to another. The purpose of discharge planning is to ensure that each resident has a planned program of continuing care which meets his/her post discharge plan of needs. The policy indicated discharge planning includes preparing the resident for the next level of care and arranging for placement in the appropriate care environment. The policy indicated the discharge planner shall develop a discharge plan for each resident in coordination with the resident and surrogate, and the IDT. All discharge planning activities and pre-discharge preparation and a follow-up after discharge are to be documented in the resident's health record. A post-discharge plan of care is developed with the participation of the resident, which will assist the resident to adjust to his/her new living environment. A copy shall be retained in the resident's health record. Cross Reference F623