STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRESIDE HEALTH CARE CENTER	947 3RD STREET SANTA MONICA, CA 90403

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

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F 0572 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents a notice of rights, rules, services and charges.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide information orally and in writing of all rules and regulations governing resident conduct and responsibilities during the residents' stay in the facility for two of three sampled residents (Residents 1 and 2). This deficient practice resulted in Residents 1 and 2 discharged from the facility without proper communication and documentation of the consequences of leaving the facility. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE]th, 2020 with [DIAGNOSES REDACTED]. affects the way the body processes blood sugar), and major [MEDICAL CONDITION] (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]th, 2019 with [DIAGNOSES REDACTED]. in activities, causing significant impairment in daily life). A review of Resident 2' Order Summary Report dated May 30th, 2020 with no end date, indicated an active order that resident may go out on therapeutic pass with self or responsible party. During an interview with the Director of Nursing (DON) on September 11th, 2020 at 12:22 PM, the DON stated Resident 1 did not usually go out, and this was the first time he left the facility for non-medical reason. The DON further stated that the facility had not notified all residents of the consequences of leaving the facility during coronavirus (COVID-19- new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans, respiratory illness that can spread from person to person). During an interview with Resident 1 on September 11th, 2020 at 1:53 PM, Resident 1 stated he was not told that if he left the facility for other reasons he would not be able to return. During an interview with the DON on September 14th, 2020 at 11:00 AM, the DON stated and confirmed Resident 1 was not present during the conversation between the Administrator and Resident 2 regarding leaving the facility. During an interview and a concurrent record review with the DON on September 14th, 2020 at 11:10 am, the DON stated and confirmed Resident 2 had an order to go out on pass. During an interview and a concurrent record review with the Assistant Administrator (AA), on September 14th, 2020 at 4:00 PM, the AA stated the Administrator met with the residents on May 29th, 2020 and informed them that they are not allowed to leave the facility at any time without coordinating with the facility because of the current COVID 19 restrictions. AA stated and confirmed there was incomplete documentation regarding this meeting between Resident 2 and Administrator. The AA further stated there was no signature from the Administrator. The document does not indicate a signature from Resident 2. Resident 1 was not mentioned in the paragraph summarizing the meeting on May 29th, 2020. The AA further stated and confirmed there was no documentation of communication with Resident 1 and no warnings of leaving the facility was documented in Resident 2's medical record. During an interview with the AA on September 14th, 2020 at 4:15 PM, the AA stated the residents did sign the inventory list however, the AA was unable to provide documnetation Residents 1 and 2 signed leaving the facility Against Medical Advise (AMA). During an interview with the AA on September 17, 2020 at 10:00 AM, the AA stated the Administrator notified the doctor, however the AA was not sure what the doctor said. The AA stated Residents 1 and 2 were not allowed back to the facility due to COVID-19 risk. The AA was unable to provide documentation indicating the Residents 1 and 2 were informed they would be discharged if they left the facility due to COVID-19 risk. During an interview with the AA and DON, on September 17, 2020 at 10:05 AM, the AA stated the Residents 1 and 2 were informed that it could be determined as leaving AMA if they left the facility. However, the AA and the DON were unable to provide documentation of the possibility of dicharging Residents 1 and 2 leaving AMA. There was no documnentation Residents 1 and 2 signed the AMA form. The AA was unable to provide documnetation Residents 1 and 2 stated they did not want to return to the facility. The facility's policy and procedure tilted, Leaving Against Medical Advise, revised on March 25th, 2018, indicated, attempts shall be made to locate the resident . in those cases where the residents can be contacted, the residents;s desire to return or not to return to the facility shall be documented. Documentation shall reflect risks, benefits, and alternatives discussed; as well as discussion of current medical condition and reason why stay in facility is desirable. The facility's policy and procedures titled, Transfer or Discharge Documentation, with revised date of December 2016, indicated, the basis for the transfer or discharge; that an appropraite notice was provided to the resident and/or legal representative.
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 ensure there was notifications of the discharge, the date of discharge, and the reasons for the dicharge in writing prior to the discahrge, and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for two of three sampled residents (Residents 1 and 2). These deficient practices resulted in incomplete discharge documentation with the potential to impede the continuity of care for Residents 1 and 2. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE]th, 2020 with [DIAGNOSES REDACTED]. affects the way the body processes blood sugar), and major [MEDICAL CONDITION] (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]th, 2019 with [DIAGNOSES REDACTED]. in activities, causing significant impairment in daily life). A review Resident 2's Order Summary Report dated on May 30th, 2020 with no end date, indicated an active order Resident 2 might go out on therapeutic pass with self or responsible party. During an interview with the Director of Nursing (DON) on September 11th, 2020 at 12:22 PM, the DON stated Resident 1 did not usually go out, and this was the first time he left the facility. The DON further stated the facility had not communicated with Residents 1 and 2 the restriction on leaving the facility during coronavirus (COVID-19- new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans, respiratory illness that can spread from person to person). During an interview with Resident 1 on September 11th, 2020 at 1:53 PM, Resident 1 stated he was allowed to go to doctor appointments while in the facility. Resident 1 further stated he was not informed if he left the facility he would not be allowed in. During an interview with the DON on September 14th, 2020 at 11:00 AM, the DON stated and confirmed Resident 1 was not informed of the consequences of leaving the facility due to COVID 19 restrictions. During interview and a concurrent record review with the DON, on September 14th, 2020 at 11:10 am, the DON stated and confirmed Resident 2 had an order to go out on pass. The DON was unable to provide documentations of notification before discharge a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman. During interview and a concurrent record review with the Assistant Administrator (AA), on September 14th, 2020 at 4:00 PM the AA stated that the administrator met with the residents on May 29th, 2020 and informed Residents 1 and 2 they were not allowed to leave the facility at any time. The documentation of provided by the AA of the conversation between the Administrator and Resident 2 had no signatures from both the

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Administrator and Resident 2. Resident 1 was not mentioned in the paragraph summarizing the meeting on May 29th, 2020. AA stated and confirmed there was no documentation of communication with Resident 1 and no further warnings documented in medical record. The AA was unable to provide documentations of notification before discharge that a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman. During an interview with AA on September 14th, 2020 at 4:00 PM, the AA stated that the residents did sign something when they were discharged from the facility as AMA, but it was an inventory list, and not an AMA form. During an interview with AA on September 17, 2020 at 10:00 AM, the AA stated that she was in the facility the day Residents 1 and 2 left AMA. AA stated that she and the Administrator were both in meetings that morning, and they were notified around late morning to early afternoon that Residents 1 and 2 had left the facility, and the residents returned sometime after lunch to late afternoon. AA stated that she doesn't remember the exact time. AA stated that a couple people witnessed the residents leave, one of the CNAs saw them in the car driving away, and the staff was not able to find them in the building. AA stated not sure which CNA or staff member saw the residents leave. During an interview with the Social Service Director (SSD) on September 17, 2020 at 10:10 AM, the SSD stated Residents 1 and 2 were discharged from therapy and were receiving custodial care. The SSD further stated the discharge planning was in the process for Residents 1 and 2. The SSD further stated there was no notice to ombudsman, and no 30 day notice given o residents. During an interview with the DON on September 17, 2020 at 10:15 AM, the DON confirmed the finding and stated this is not the normal process for discharging a resident. During an interview with the AA on September 17, 2020 at 10:20 AM, the AA stated the facility was responsible to carry out a proper discharge for both of these residents. The AA further stated Resident 1 was not aware he could not return to the facility. During an interview with the AA and DON on September 17, 2020 at 10:35 AM, the AA and the DON confirmed the findings and stated they understood why the facility's method of discharging Residents 1 and 2 was a cause for concern. The facility's policy and procedure tilted, Leaving Against Medical Advise, revised on March 25th, 2018, indicated, documentation shall reflect risks, benefits, and alternatives discussed; as well as discussion of current medical condition and reason why stay in facility is desirable. The facility's policy and procedures titled, Transfer or Discharge Documentation, with revised date of December 2016, indicated, the basis for the transfer or discharge; that an appropraite notice was provided to the resident and/or legal representative.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility for two of three sampled residents (Residents 1 and 2). This deficient practice had the potential to cause anxiety to Residents 1 and 2 as they were unaware they would be discharged from the facility. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE]th, 2020 with [DIAGNOSES REDACTED]. affects the way the body processes blood sugar), and major [MEDICAL CONDITION] (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]th, 2019 with diagnoeis including post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), [MEDICAL CONDITION] (group of lung diseases that block airflow and make it difficult to breathe), borderline personality disorder (mental disorder characterized by unstable moods, behavior, and relationships), and major [MEDICAL CONDITION] (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During an interview with the SSD on September 11, 2020 at 12:00 PM, the SSD was unable to provide documentation Residents 1 and 2 were given sufficient preparations and orientation to ensure a sfae and orderly discharge form the facility. During an interview with the Director of Nursing (DON) on September 11th, 2020 at 12:22 PM, the DON stated Resident 1 did not usually go out. The DON further stated the facility had not notified Residents 1 and 2 of the consequences of leaving the facility. During an interview with Resident 1 on September 11th, 2020 at 1:53 PM, Resident 1 stated he was not informed of the discharge prior to leaving to the glocery. During an interview with the DON on September 14th, 2020 at 11:00 AM, DON stated and confirmed that Resident 1 was not informed of the dicharge prior to leaving the facility to the glocery store with resident 2. During interview and a concurrent record review with the DON, on September 14th, 2020 at 11:00 am, the DON stated and confirmed Resident 2 did have an order to go out on pass. The DON stated and confirmed Residents 1 and 2 were not provided sufficient preparartion prior to their discharge. During interview and a concurrent record review with the Assistant Administrator (AA), on September 14th, 2020 at 4:00 PM, the AA stated that the Administrator met with Residents 1 and 2 on May 29th, 2020 and informed them that they are not allowed to leave the facility, however, the AA was unable to provide documnetation Resident 1 and 2 signed an documents regarding requesting for a discharge from the facility. Resident 1 was not mentioned in the paragraph summarizing the meeting on May 29th, 2020. The AA stated and confirmed there was no documentation of communication with Resident 1 regarding leaving the facility. During an interview with the AA on September 14th, 2020 at 4:00 PM, the AA stated Residents 1 and 2 left the facility Against Medical Advice (AMA), however the AA was unable to provide a signed AMA form from Residents 1 and 2. During an interview with the SSD on September 17, 2020 at 10:00 AM, the SSD stated that residents left late morning to early afternoon and returned about 2 hours later. The SSD further stated Residents 1 and 2 were discharged from therapy and were receiving custodial care, discharge planning was in the process. During an interview with the DON on September 17, 2020 at 10:15 AM, DON stated this is not the normal process for discharging a resident. During an interview with the AA on September 17, 2020 at 10:30 AM, the AA stated she understood the facility was responsible to carry out a proper discharge for both Residents 1 and 2. The AA further stated there was a concern for Residents 1 being discharged . During an interview with the AA and DON, on September 17, 2020 at 10:40 AM, the DON and AA stated they understood why the method of discharging Resident 1 and 2 is a cause for concern. The facility's policy and procedures titled, Discharging the Resident, with revised date of December 2016, indicated, the resident should be consulted about the discharge. Discharges can be frightening to the resident. Approach the discharge in a positive manner. The facility's policy and procedures titled, Transfer or Discharge Documentation, with revised date of December 2016, indicated, when a resident is transfered or discharged from the facility, the following information will be documented in the medical record: if the resident is being transfered or discharged because his or her needs cannot be met at the facility, documnettation will include: the specific resident needs that cannot be met, the facility's attempt to meet those needs, and the receiving facility's service (s) that are available to meet those needs.
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 implement effective discharge planning process by not following the facility policy as outlined in Leaving Against Medical Advice for two of three sampled residents (Residents 1 and 2). These deficient practices had the potential of prematurely discharging residents who may have required continued care in the facility. Findings: A review Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE]th, 2020 with [DIAGNOSES REDACTED]. affects the way the body processes blood sugar), and major [MEDICAL CONDITION] (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]th, 2019 with [DIAGNOSES REDACTED]. in activities, causing significant impairment in daily life). A review of Resident 2's Order Summary Report dated on May 30th, 2020, with no end date indicated an active order that resident may go out on therapeutic pass with self or responsible party, order. During an interview with the Director of Nursing (DON) on September 11th, 2020 at 12:22 PM, the DON confirmed the findings and stated Resident 1 did not usually go out, and this was the first time he left the facility. The DON further stated the facility had not notified all residents of the consequences of leaving the facility. During an interview with Resident 1 on September 11th, 2020 at 1:53 PM, Resident 1 stated he was not told that if he left the facility he would not be able to return. Resident 1 was discharged to a guest home on July 8, 2020, at 9:32 PM. During an interview with the DON on September 14th, 2020 at 11:00 AM, DON stated and confirmed that Resident 1 was not in on the conversation between the administrator and Resident 2 regarding not using Resident 2's car to leave the facility due to COVID 19 restrictions. During interview and a concurrent record review with the DON, on September 14th, 2020 at 11:15 am, the DON stated and confirmed Resident 2 did have an order to go out on pass. The DON was unable to show completed documentation basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation was not discussed with the resident or

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) resident's representative. There was no relevant resident information incorporated into the discharge plan or the plan of care to avoid unsafe discharge. During interview and a concurrent record review with the Assistant Administrator (AA), on September 14th, 2020 at 4:00 PM, the AA stated the Administrator met with Residents 1 and 2 on May 29th, 2020 and informed them that they are not allowed to leave the facility at any time. The AA further stated there was partial documentation on a word document regarding this meeting between Resident 2 and Administrator. The AA further stated there was no signature from the Administrator and Resident 2 indicateing the meeting did occured. The document does not indicate a signature from Residents 1 and 2. Resident 1 was not mentioned in the paragraph summarizing the meeting on May 29th, 2020. The AA stated and confirmed there was no documentation of any communication with Resident 1 regarding leaving the facility. The AA further stated she thought verbal communication was sufficient. The facility did not develop and implement an effective discharge planning process that focuses on Residents 1 and 2's discharge goals. The facility's discharge planning process was not consistent with the discharge rights The facility's policy and procedures tilted Leaving Against Medical Advise, revised on March 25th, 2018, indicated, documentation shall reflect risks, benefits, and alternatives discussed; as well as discussion of current medical condition and reason why stay in facility is desirable.