STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAS FLORES CONVALESCENT HOSPITAL	**14165 PURCHE AVE. GARDENA, CA 90249**

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 -** 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 interviews and record review, the facility failed to adhere to its policy and procedures and ensure a resident's transfer and discharge was safe, appropriate, and the resident did not require the services of a skilled nursing facility (SNF) for two of four sampled residents (Residents 1 and 2). Resident 1 was homeless for eight (8) days after being discharged from the SNF to the street against his wishes on 3/4/2020 and without an appropriate discharge plan. Resident 2 was discharged to a hotel on 11/21/19 and was admitted into a general acute care hospital (GACH) on 11/23/19 for chest pain. These deficient practices resulted in Resident 1 being admitted to the GACH on 3/12/2020 for neck/chest pain and hypertension (high blood pressure) urgency requiring surgery for [REDACTED]. Resident 2 was readmitted back to the facility for chest pain recovery after a three (3) day hospitalization . Findings: a. A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's history and physical (H/P), dated 9/5/19 indicated Resident 1 had the mental capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 12/4/19 indicated Resident 1 was able to be understood and understand others. The MDS indicated Resident 1 required a one-person physical assist for dressing, personal hygiene and supervision to eat. The MDS indicated Resident 1's balance was not steady during standing, walking and transfer from surface-to-surface. A review of Resident 1's care plan titled, Activities of Daily Living (ADL), dated 8/28/19 indicated Resident 1 had a self-care deficit performance related to generalized weakness, impaired balance and history left hip replacement. The staffs' interventions included to provide a sponge bath when a full shower cannot be performed and staff to assist with personal hygiene and oral care. A review or Resident 1's care plan titled, Unspecified, dated 8/28/19 indicated Resident 1's primary physician gave orders to discharge resident to a lower level of care facility on 1/13/2020. The care plan indicated a discharge was not feasible due to Resident 1 requiring long term care and the resident wishing to remain in the facility. The staffs' interventions included to assure resident/family that long-term living arranges are in place and decision to remain in the facility can be changed and evaluate discharge plan every 90 days through the review period 3/18/2020. A review of the Interdisciplinary Team ((IDT) group of medical specialist that coordinate, collaborate, and plan the delivery of care for residents) meeting, dated 2/14/2020 and attended by Social Services Director (SSD), Social Services Assistant (SSA), Activities Director (AD) and Administrator in Training (AIT) indicated Resident 1 Was informed repeatedly that after numerous opportunities, he failed to pay his share of cost for consecutive months, therefore, the facility believed placing him at a lower level of care will be a more suitable place for him to reside as he does not need to be at the facility in order to receive his medical needs. A review of the unsigned Physician's telephone order, dated 3/4/2020 and timed at 5:13 p.m., indicated to discharge Resident 1 with medications. The telephone order did not indicate the place of discharge. Multiple fails attempts made to clarify orders for discharge. A review of the unsigned and undated Physician's Discharge Summary indicated Resident 1 was discharged home on[DATE] because his health had improved sufficiently and no longer needed the services provided by the facility. A review of a Notice of Proposed Transfer/discharge date d 3/4/2020 indicated Resident 1 refused to sign the discharge form. A review of Resident 1's undated Post Discharge Plan of Care indicated Resident 1 was discharge home with medications. The discharge instructions indicated to take blood pressure medication if systolic (first number) blood pressure (BP) was greater than 160 (139/89 - 100/70 normal reference ranges (NRR)) and to hold BP medications if systolic BP was less than 110 or heart rate less than 60 beats per minute ((bpm) NRR 60-100 bpm). A review of Resident 1's Nurses Notes dated 3/4/2020 and timed at 4:53 p.m. indicated Resident 1 was discharged with medications and belongings. The nurse's notes indicated the facility provided Resident 1 with transportation (unspecified destination) did not specified. A review of the GACH's Emergency Department (ED) report, dated 3/12/2020 and timed at 1:48 p.m., indicated Resident 1 arrived at the ED complaining of neck/chest pain. The report indicated Resident 1 was kicked-out from the SNF eight (8) days prior and had been homeless living under an awning (a frame used to keep the sun or rain off a storefront, window, doorway, or deck) of a parking lot. The ED note indicated Resident 1 had a hypertensive (high blood pressure) urgency of 170/110 and was admitted for further evaluation. A review of the GACH's Procedure Report, dated 3/13/2020 and timed at 5:47 p.m., indicated Resident 1 underwent a right and left heart catheterization (long thin tube inserted in an artery or vein in the groin, neck or arm and threaded through the blood vessels to the heart) to treat severe [DIAGNOSES REDACTED] (valves become stiff and thickened having a difficult time opening and closing to pump blood throughout the body). On 1/10/2020 at 2:42 p.m., during an interview, Resident 1 stated the facility had discharged him because of not paying the share of cost ((SOC) is the amount you agree to pay for health care before Medi-Cal starts to pay). Resident 1 stated he was paying the SOC and had not received a notice for discharge. Resident 1 stated he did not want to leave the nursing home because he did not know how to take his medication and blood pressure. On 1/10/2020 at 3:38 p.m., during an interview with the Administrator in Training (AIT) and Admissions Coordinator (AC), the AIT stated Resident 1 was being discharge due to not paying his SOC. The AC stated Resident 1 received his first letter for outstanding SOC balance on 1/8/2020. The AIT stated she did not know if the physician assessed Resident 1 prior to discharging the resident. On 4/16/2020 at 11:10 a.m., during a telephone interview, the Administrator (ADM) stated Resident 1 was discharged to a lower level of care facility ((LLC) housing for the elderly or disabled people that provides nursing care, housekeeping, and prepares meals) on 3/4/2020. On 4/17/2020 at 4:09 p.m., during a telephone interview, the owner of the LLC facility stated Resident 1 was not admitted and did not have on record Resident 1's admission. The LLC owner stated not being made aware a resident was being transfer to the facility. On 4/17/2020 at 4:20 p.m., during a telephone interview, the LLC supervisor stated no records where found of Resident 1's admission or arrival to the LLC on 3/4/2020. The LLC supervisor stated they did not receive a phone call from the SNF to admit Resident 1. On 4/17/2020 at 4:48 p.m., during a telephone interview, Resident 1 stated he was thrown out of the SNF to the streets on 3/4/2020. Resident 1 stated he refused to leave and sign any documents from the facility on 3/4/2020. Resident 1 stated he explained to the facility not feeling well and needing help. Resident 1 stated he was sleeping in abandon parking lots and was taken to the GACH on 3/12/2020 due to chest/neck pain. Resident 1 stated he underwent surgery due to high blood pressure problem. Resident 1 stated he felt worthless and bad they threw him out of the facility. On 4/20/2020 at 2:18 p.m., during a telephone interview, the SNF SSD stated she did not ensure the LLC was an appropriate placement for Resident 1. The SSD stated she paid for an Uber for Resident 1 to be taken to the LLC. The SSD stated Resident 1 refused to sign the discharge documents and at the time he was discharge COVID-19 was not as bad. The SSD stated Resident 1 was given a notice for discharge to a shelter in 1/2020. The SSD stated she had to cancel the notice

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

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F 0622 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) because a shelter was not an appropriate placement for discharge for Resident 1. On 4/20/2020 at 3:26 p.m., during a telephone interview, the SNF's Registered Nurse 1 (RN 1) stated she called Resident 1's physician to initiate the discharge and perform a discharge assessment but Resident 1 refused to sign the documents for discharge because he did not want to leave the facility. RN 1 stated Resident 1 was discharge from the facility because he was non-compliant with the SOC payments. RN 1 stated she did not call the LLC to ensure Resident 1 arrived at the facility safe. b. A review of Resident 2's Face Sheet (Admission Record) indicated Resident 2 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's History and Physical (H/P), dated 5/22/19 indicated Resident 2 had mental capacity to understand and make decisions. A review of the unsigned and undated Physician's Discharge Summary indicated Resident 2 was discharged to a hotel on 11/21/19 because his health had improved sufficiently and no longer needed the services provided by the facility. A review of the SSD note, dated 11/21/19 and timed at 2:32 p.m. indicated Resident 2 was given $216.00 and discharge to a hotel via taxi. The SSD note indicated Resident 2 needed to be at the shelter no later than 1:30 p.m. to be admitted . The SSD note indicated the facility gave Resident 2 money for two nights to stay at the hotel. On 4/20/2020 at 2:18 p.m., during a telephone interview, the SSD stated she process Resident 2's discharge to a hotel on 11/21/19. The SSD stated Resident 2 was admitted to a GACH for chest pain two days after his discharge to the hotel and then transfer back to the facility on [DATE] from the GACH. The SSD stated she knew discharging the residents to a shelter was not a safe and appropriate discharge. A review of the facility's policy and procedures, revised on 5/1/18 and titled, Transfer and Discharge, indicated the facility was responsible to ensure a complete, safe and appropriate discharge planning and necessary information is provided to the continuing care provider. The policy indicated when the facility anticipates a resident's discharge to an LLC facility, the IDT with the assistance of the resident would develop a discharge summary and post-discharge plan to assist the resident to adjust. The policy indicated the medical record should contain written documentation from the resident's physician regarding the reason for transfer and enough evidence of the attempts from the facility to address residents needs.
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.** Based on interview and record review, the facility failed to provide the correct State agency as point of contact for appeals on the notice of proposed transfer form for two of four sampled residents (Residents 1 and 2), and notify the Local Ombudsman (program designed to identify, investigate, and resolve complaints made by or on behalf of residents) of Residents 1 and 2 transfers. The point of contact for appeals on the Notice of Proposed Transfer/Discharge form, which was given to Residents 1 and 2 indicated the Office of Administrative Hearings and Appeals (OAHA) located in Van Nuys CA instead of Sacramento CA. This deficient practice may jeopardize the ability of the State hearing agency to render a decision on the appeal if the appeal was not submitted within 10 calendar days as suggested and for Ombudsman to intervene for residents when needed. Findings: A review of Residents 1 and 2 Notice of Transfer/Discharge indicated the wrong address and telephone number for Residents 1 and 2 to contact the Office of Administrative Hearings Appeals (OAHA) to appeal the transfer/discharge. Residents 1 and 2 were referred to the local Regional office instead of the Sacramento California address. On 1/10/2020 at 5 p.m., during an interview and concurrent review of the Notice of Proposed transfer/discharge form for Residents 1 and 2, the Administrator in Training (AIT) stated Residents 1 and 2 were given the wrong address to appeal their transfers if they wished to. The AIT indicated Residents 1 and 2 were provided the local Regional address instead of the Sacramento address. On 4/20/2020 at 2:18 p.m., during a telephone interview, the Social Services Director (SSD) stated she did not ensure the Lower Level of Care ((LLC) housing for the elderly or disabled people that provides nursing care, housekeeping, and prepares meals) facility was an appropriate placement for Resident 1. The SSD stated she paid for an Uber (ride sharing company) for Resident 1 to be taken to the LLC (sic). The SSD stated Resident 1 was given a notice to be discharged to a shelter and Resident 2 to a hotel. The SSD stated she had to cancel the first discharge notice because she was made aware a shelter was not an appropriate placement for discharge. On 4/24/2020 at 3:02 p.m., during a telephone interview, the Ombudsman representative stated the facility has not notified or sent any written notice of proposed transfer to the Ombudsman office since 11/2019. A review of the facility's policy and procedures, revised on 5/1/18 and titled, Transfer and Discharge, indicated that facility would provide the residents with the phone number and address to appeal the discharge. The policy indicated the facility would send a copy of the Notice of Transfer/Discharge to the State Long Term Care Ombudsman for the facility-initiated discharges.