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 _____	04/03/2020

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.

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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 identify and document discharge needs, make post-discharge and referrals arrangements for one of three sampled residents (Resident 1). This deficient practice had the potential for interrupted continuity of care, and necessary follow-up appointments. Findings: A review of Resident 1's Admission Record, indicated the facility initially admitted the resident, a [AGE] year old male, on [DATE] with [DIAGNOSES REDACTED]. (chronic illness that involves compulsive behaviors that manifest as cravings, inability to control use, and continued use of a drug altering the mind despite its harmful consequences). A review of Resident 1's Minimum data Set (MDS, standardized assessment and care-screening tool) dated [DATE], indicated the resident had capacity to understand and make decisions, was independent and or required one person assistant for perform activities of daily living (ADL, bathing, grooming, walking, hygiene and toileting). The MDS indicated Resident 1 was not steady from seated to standing position, walking, turning, moving on and off toilet, and surface transfer. The MDS indicated the resident had no impairment to both upper and lower extremities, however, he uses a wheelchair for mobility. A review of Resident 1's Discharge Note from General Acute Care Hospital 1 (GACH 1), dated [DATE], indicated the resident had a history of [REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of a Resident 1's physician's phone order dated [DATE]20 timed 11:00 p.m., indicated to discharge the resident to a friend's address and to give the resident, [MEDICATION NAME] 10/325 milligrams (mg, unit dose) 9 tablets only one time only for 1 day. The physician order did not indicate the frequency and or dosage for [MEDICATION NAME]. A review of Resident 1's undated discharge care plan, indicated to explain his medication, dosage, purpose and frequency. A review of Resident 1's progress notes dated [DATE]20 timed 10:30 p.m. indicated May release [MEDICATION NAME] 10/325 milligrams (mg, unit dose) x 10 tablets. Educated the resident and demonstrated medication regimen and reason for medication. Educated and demonstrated with return demonstration how to take a pulse, blood pressure, and wound management. However, the progress note did not indicate how the resident would access or if the facility provided the resident with wound management supplies, equipments for monitor/record blood pressure, how to identify and to whom to report abnormal blood pressure and or pulse, or any changes in the resident's wound. The progress note did not indicate when and how the resident would access home-health management, and specialist referrals. During an interview on [DATE]20 at 11 a.m., the SSD stated Resident 1 needed to be transferred to a lower level of care and did not need to be in a skilled nursing facility because he was OOP almost daily. The SSD stated Resident 1 verbalized that he needed to stay at the facility, but he was using the facility as a place to live in. A review of Resident 1's Social Services Notes dated from 10/2/2019 to 1/30/2020, did not indicate SSD attempted to initiate discharge planning for the resident. During an interview on 3/21/2020 at 3:45 p.m., RN 1 stated she could not recall if the facility gave Resident 1 discharge instructions. RN 1 stated she would have noted any home-health arrangements, referrals and or upcoming medical appointments in the post-discharge plan of care. RN 1 stated there was no documentation in the resident's medical records. RN 1 stated the resident was very eager to be discharged . During a phone interview and record review with LVN 2 on [DATE]/2020 at 11 a.m., LVN 2 stated Resident 1 returned to the facility on [DATE] at 10:30 p.m., and was discharged from the facility the same night. LVN 2 stated, there was no documented evidence that hepatologist (liver specialist), oncologist (a specialist in diagnosing and [MEDICAL CONDITION]), cardiologist (heart specialist), mental health referrals, or home health arrangements were made for Resident 1. A review of the facility's policy and procedures, titled Discharge/Home, dated 11/2017, indicated the facility: 1. Must adequately prepare the resident and the family for a smooth discharge and must ensure appropriate home care arrangements have been made. 2. Social services must initiate contact with a home health agency to ensure continuity of care as deemed appropriate. 3. Must provide the resident with all the discharge instructions, medications, and follow-up clinic appointments. 4. Social services and nurse must ensure that all sections of the discharge forms are complete. A review of the facility policy and procedures, titled Policy and Procedure on Out on Pass/AMA/Doctor Appointment, dated 5/2012, indicated the facility must respect the resident's rights to be OOP unless otherwise contraindicated to the resident's medical needs. The policy indicated the rule would be based on AMA requirement if the resident would decide to go against medical advice and was responsible for self.
F 0710 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a physician's order for, and notify Medical Doctor 1 (MD 1) of a 7-day therapeutic leave for one of three sampled residents (Resident 1). These deficient practices, resulted in Resident 1's lack of supervision by the facility staff for 7 days, and had the potential to threaten the resident's safety. (Cross Reference with F660) Findings: A review of Resident 1's Admission Record, indicated the facility initially admitted the resident on [DATE] with [DIAGNOSES REDACTED]. (chronic illness that involves compulsive behaviors that manifest as cravings, inability to control use, and continued use of a drug altering the mind despite its harmful consequences). A review of Resident 1's Minimum data Set (MDS, standardized assessment and care-screening tool) dated [DATE], indicated the resident had capacity to understand and make decisions, was independent and or required one person assistant for perform activities of daily living (ADL, bathing, grooming, walking, hygiene and toileting). The MDS indicated Resident 1 was not steady from seated to standing position, walking, turning, moving on and off toilet, and surface transfer. The MDS indicated the resident had no impairment to both upper and lower extremities, however, he uses a wheelchair for mobility. A review of Resident 1's Discharge Note from General Acute Care Hospital 1 (GACH 1), dated [DATE], indicated the resident had a history of [REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of Resident 1's progress notes indicated the resident went OOP on: [DATE] and returned at 7:15 p.m. No time was indicated when the resident went OOP. 1[DATE]19 at 2:50 p.m., and no return time to the facility. No known address/destination. [DATE] at 6:10 p.m. to see a friend, and returned to the facility on [DATE] at 1:30 a.m. A review of the Nurses Note, dated 1/19/2020, Licensed Vocational Nurse 1 (LVN 1) documented that the Social Services Director (SSD) informed Nurse Practitioner 1 (NP 1) that Resident 1 was out on pass (OOP, authorized temporary absence from the facility) for more than 12 hours and a new order was made and carried out. A review of the Nurses Note, dated 1/24/2020, the Director of Nursing (DON) documented that she spoke to Resident 1 regarding physician's order for 4-hour OOP. The note indicated the DON explained to the resident that if he goes out beyond 4 hours, he could be discharged from the facility against medical advice (AMA, leave the facility against the advice of the physician). The note indicated Resident 1 stated he needed an OOP order for at least 12 hours to reconnect and spend hours with his friends. The note indicated the DON explained to Resident 1 that the facility would be liable if something happens to him outside of the facility. During an interview on [DATE]20 at 11 a.m., the SSD stated Resident 1 needed to be transferred to a lower level of care and did not need to be in a skilled nursing facility because

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

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F 0710 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) he was OOP almost daily. The SSD stated Resident 1 verbalized that he needed to stay at the facility, but he was using the facility as a place to live in. The SSD stated the facility presented Resident 1 with the therapeutic leave option during the IDT meeting to make a point that Resident 1 had a place to live in, if he was discharged from the facility. The SSD stated the DON spoke with NP 1 regarding the order for 7-day therapeutic leave. During an interview on [DATE]20 at 12:11 p.m., the DON stated the Administrator suggested to Resident 1, to take a therapeutic leave to test how he could care for himself, and if any of the resident's friends would allow the resident to live with them when discharged from the facility. The DON stated the facility did not have Resident 1's temporary address, nor obtained any contact information of Resident 1's friends while the resident went OOP and or on 7 day therapeutic leave. The DON stated the facility staff communicated with Resident 1 via the resident's cellphone. The DON stated she obtained the 7-day therapeutic leave order from NP 1 after the IDT meeting dated. During an interview on [DATE]20 at 12:27 p.m., the Administrator stated, MD 1 did not agree for Resident 1 to go OOP for 12 hours as per the resident's request. The Administrator stated, he presented the resident with the 7 day therapeutic leave option to enable the resident to transition and readapt to the life outside the facility. The Administrator stated the facility must obtain a physical address and a phone number to reach Resident 1, and the facility did not. The Administrator stated the facility was responsible for the resident. During an interview on [DATE]20 at 2:56 p.m., Registered Nurse 2 (RN 2) stated, Resident 1 would go OOP for more than 4 hours at times to go to the store and visit multiple friends. RN 2 stated Resident 1 smelt like marijuana (a recreational drug) when the resident returned form OOP. RN 2 stated the facility did not conduct a drug test (evaluation of urine, blood, or another type of biological sample to determine if the person has been using any drug/s). RN 2 stated he escorted Resident 1 to the resident's friend's car on 1/30/2020 at 10:45 p.m., when the resident went on the 7-day therapeutic leave. RN 2 stated he did not know the name of the resident's friend or the address the resident was going to. RN 2 stated, Resident 1 responded This is just for the night and tomorrow, I don't know where I am going, so I will have to go to my other friend's house when RN 2 enquired where the resident was going. A review of Resident 1's undated therapeutic leave care plan, indicated to reassess the resident when he comes back form therapeutic leave and notify MD for any abnormal findings. A review of the Interdisciplinary Team (IDT, group of professionals from different disciplines who collaborate to attain the goals of care for the resident) Care Conference Note, dated 1/29/2020, indicated Resident 1 was upset because he wanted the facility to grant him a 12-hour OOP, but his primary physician (MD 1) only authorized a 4-hour OOP. The note indicated Resident 1 did not feel like discharging from facility and stated that he is sick. The note indicated that the Administrator suggested that resident can have therapeutic leave and the facility would hold the bed for 7 days in order for the resident to become independent with his medications and be able to take care of himself. A review of Resident 1's Order Summary Report indicated the following physician's orders dated: 1/19/2020, indicated May go out on pass x 4 hours. If resident exceeds the allowed time, may discharge AMA. 1/31/2020, Indicated May have therapeutic leave for 7 days to reconnect with friends and reintegration for discharge planning. However, there was no physician's order on Resident 1's medical record. A review of the Nurses Note, dated 1/30/2020 timed at 10 p.m., indicated Resident 1 left the facility for 7-day therapeutic leave with medications (Meds?)for 7 days. A review of Resident 1's progress notes dated [DATE]20, timed 10:30 p.m., indicated the resident came back from OOP, and requested to be discharged the same night, and provided an address of where he was going to. The progress note indicated the facility released [MEDICATION NAME] 10/325 mg x 10 tablets. However, a review of Resident 1's physician's phone order dated [DATE]20, timed 11:00 p.m., indicated to discharge the resident to a friend's address and to give the resident, [MEDICATION NAME] 10/325 milligrams (mg, unit dose) 9 tablets only one time only for 1 day, no frequency and or dose was indicated. During an interview on [DATE]20 at 12:11 p.m., the DON stated she obtained the 7-day therapeutic leave order from NP 1 after the IDT meeting. During an interview on [DATE]20 at 12:27 p.m., the Administrator stated MD 1 did not agree to let Resident 1 OOP for 12 hours as requested by the resident. The Administrator stated he then presented to Resident 1 the option to take a therapeutic leave of up to 7 days to transition and readapt to the life outside the facility. During an interview on [DATE]20 at 2:56 p.m., RN 2 stated Resident 1 would go OOP for more than 4 hours at times because the resident would have to take the bus to go to the store and visit multiple friends. RN 2 stated Resident 1 would smell like marijuana when coming back from OOP, but this was not confirmed since the facility did not conduct any drug testing (evaluation of urine, blood, or another type of biological sample to determine if the person has been using any drug/s). RN 2 stated he escorted Resident 1 to the gate of the facility as the resident was picked up by his friend's car on 1/30/2020 at 10:45 p.m. for the 7-day therapeutic leave. RN 2 stated he did not know the name of the friend or the address he was going to. RN 2 stated he asked Resident 1 where he was going and Resident 2 stated, This is just for the night and tomorrow, I don't know where I am going, so I will have to go to my other friend's house. RN 2 stated he gave Resident 1 six tablets of [MEDICATION NAME] (controlled drug used to treat moderate to severe pain), [MED] (medication used to treat and prevent blood clots and can cause bleeding) for 7 days, and [MEDICATION NAME] (medication used to treat high blood pressure) for 4 days. RN 2 did not state the medication instructions RN 2 provided Resident 1 before the resident went OOP. A review of Resident 1's Order Summary Report Active Orders As From 1/1/2020, indicated the resident to have: [MEDICATION NAME] tablet 10-325 milligrams (mg, unit dose) 1 tablet every 6 hours as needed for pain. [MEDICATION NAME] 25 mg by mouth twice a day to hold is systolic blood pressure (SBP, upper number on blood pressure recording) and for heart rate (HR) less than 50. [MED] ([MED]) 20 mg 1 tablet by mouth in the evening. During a telephone interview on [DATE]at 1:35 p.m., MD 1's Assistant (MDA) stated he was not aware of the 7-day therapeutic leave without facility supervision for Resident 1. MDA stated MD 1 would have communicated with him if MD 1 would have known about or authorized the 7-day therapeutic order. MDA stated he was only aware of MD 1 authorizing a 4-hour OOP order for Resident 1, since the facility staff members were concerned about the resident's and the other residents' safety when Resident 1 comes back to the facility from being OOP. During a phone interview on [DATE]at 2:19 p.m., NP 1 stated MD 1 did not want to authorize more than 4 hours of OOP because Resident 1 was believed to have connections with old friends using illegal drugs. NP 1 stated no drug testing was done while Resident 1 was at the facility. NP 1 stated she was not aware that Resident 1 was placed on a 7-day therapeutic leave and that she was not allowed to give that order. NP 1 stated it was not safe for him to be OOP to reconnect with old friends, especially since the facility would be responsible for him. NP 1 stated if he would not accept and comply with the physician's order of 4-hour OOP, the resident could leave against medical advice (AMA) and sign the release papers. NP 1 stated that in order to ensure a safe discharge, Resident 1 should have been discharged to an independent living facility with home health nurse visits necessary for at least 6 weeks to follow up with the resident's adherence to the medication regimen and the physician's appointments, his mental health condition related to his history of substance abuse, and monitoring of blood tests to prevent any rehospitalization or relapse. A review of the facility's policy and procedures, titled Verbal Orders, dated 2/2014, indicated verbal orders must only be given in an emergency or when the Attending Physician is not immediately available to write or sign the order. The policy indicated the practitioner must review and countersign verbal orders during his or her next visit. The policy indicated that a person writing an unauthorized verbal order must be subject to disciplinary action.