STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST GARDENA POST ACUTE	**16530 S BROADWAY STREET GARDENA, CA 90248**

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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's nursing staff failed to ensure the readmission for one selected resident (Resident A). Resident A left the facility via an ambulance after he called emergency services (911) to take him to a general acute care hospital (GACH). The following evening (11 p.m.) Resident A returned to the facility and was refused admission. Per staff interview Resident A self-discharged by calling 911 to go to a GACH without a physician's orders [REDACTED]. Findings: A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. A Minimum Data Set (MDS), an assessment care and screening tool, dated 1/1[DATE]9, indicated Resident A's cognitive skills for daily decision-making were intact. Resident A required extensive one-person assist for bed mobility, transfers and to complete his activities for daily living (normal daily task such as eating, bathing, dressing, grooming and toileting). Resident A had a functional limitation in range of motion (the distance and direction a joint can move to its full potential) to both of his lower extremities and was incontinent (involuntary voiding of urine and stool) of both bowel and bladder functions. A review of Progress Notes (Nurses), dated 3/7/19 at 3:48 p.m., indicated Resident A wanted to go to the GACH right away. Resident A indicated he did not want to wait on the physician to give an order and that he was going to call 911. Paramedics arrived and transported Resident A to the GACH via a gurney. Resident A's physician was made aware. A review of Progress Notes (Nurses), dated 3/8/19, at 11 p.m., indicated Resident A was seen in a wheelchair outside the facility banging on the door. At 11:02 p.m., the local police department was called. At 11:10 p.m., the local police department arrived, and it was explained to them that Resident A did not have transfer orders from his physician and discharged himself from the facility and has returned without a gurney, ambulance, or report from the hospital. The police were told Resident A was no longer the facility's resident and was no longer under their care. At 11:45 p.m., the officers and Resident A left the building. Later (no time given) that evening, Resident A got into the facility and the police were called again. Resident A was not readmitted to the facility. On 3/5/19 at 6 p.m., during an interview, the Director of Nursing (DON) stated Resident A was alert and oriented times four (name, place, dated, time). The DON stated Resident A wanted to go to the GACH (3/7/19), they tried to convince him to wait for his physician's orders [REDACTED]. The DON stated Resident A called 911, the paramedics came and transferred him to a GACH. The DON stated Resident A returned to the facility the next evening around 11 p.m., he was banging on the door, the staff were afraid, and called the police. The DON stated the staff at the facility and the other residents were afraid of Resident A because of his behavior. The DON stated when Resident A called 911 himself and left the facility without a physician's orders [REDACTED]. The DON stated Resident A's physician ordered not to readmit the Resident A back to the facility. When Resident A returned the following evening banging on the door the staff were afraid and called 911. The DON acknowledged Resident A was still under a seven-day bed hold and was still their resident but stated she has an obligation to protect her staff and other residents who are in the facility and everyone was afraid of Resident A. A review of Resident A's clinical records indicated no written documentation, physician's orders [REDACTED]. A facility policy and procedure titled Against Medical Advice (AMA) Leaving the Community dated 12/2014, indicated in the event a resident or legal representative on behalf of the resident desires to leave the community against medical advice, the staff of the community will notify the physician; and have the resident or legal representative sign the release forms. The licensed nurse/designee discusses the risk of leaving the facility against medical advice with the resident or the legal representative and documents in the nurses notes or electronic documentation equivalent accordingly. The social service director/designee is involved as applicable. If the resident or the legal representative continues to desire to leave the facility, the licensed nurse encourages the resident or the legal authority to consult with the attending physician. The licensed nurse ensures the resident or legal representative signs the against medical advice (AMA) form. The licensed nurse places the AMA form in the resident's medical record. The licensed nurse/designee documents the staff/family//resident interactions regarding the desire to leave AMA in the progress notes or electronic equivalent. Should the resident or legal representative refuse to sign the release, the licensed nurse/designee writes refused to sign on the release form. One clinical staff member will sign, and one clinical staff member will witness the release form.

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.