STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055674	A. BUILDING _____ B. WING _____	**03/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTHCARE CENTER OF ORANGE COUNTY	**9021 KNOTT AVE BUENA PARK, CA 90620**

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(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 -** Minimal harm or potential for 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 interview and medical record review, the facility failed to ensure two of four closed record sampled residents (Residents 1 and 2) were safe to transfer to a lower level of care. Residents 1 and 2 were transferred and discharged to a room and board facility (a residential home not licensed to provide care and supervision to their residents, the residents are expected to manage their medication, transportation, and other needs on their own). The facility failed to ensure Residents 1 and 2 were assessed by the physician and the physician had agreed and documented whether the residents discharge was appropriate, and the residents' health had improved sufficiently to ensure the lower level of care could safely meet their needs. * Resident 1 required her medications to be administered to her. Resident 1 was assessed as a high risk for elopement but was transferred to an unlicensed and unsupervised room and board home that did not provide any medical services or supervision. Resident 1 eloped from the room and board facility twice and was missing for six days. When Resident 1 eloped the second time, her whereabouts were unknown as of 3/10/2020. * Resident 2 required extensive assistance with her ADL care and was wheelchair bound but was transferred to an unlicensed room and board facility that did not provide medical services or have a wheelchair ramp, where Resident 2 was refused admittance. The facility (SNF) then arranged for Resident 2 to transfer to another unlicensed room and board facility where Resident 2 was left unattended in the front yard and was found crying and scared. Resident 2 was also denied admittance to the second room and board facility due to Resident 2 requiring extensive assistance with ADL care and being non-ambulatory. These failures placed Residents 1 and 2 at risk for a decline in their health condition and potential for injury, neglect, and harm Findings: According to the Orange County Health Care Agency, room and board facilities are not licensed to provide care and supervision to their residents. Residents are expected to manage their medication, transportation, and other needs on their own. According to the Orange County Health Care Agency, the Public Guardian serves the community by providing investigative and fiduciary services to adults who are unable to provide their own basic personal needs due to a severe mental disorder or disabling physical condition. The Superior Court determines whether a conservatorship should be established. Conservatorship referral criteria includes grave disability due to a mental disorder and being unable to provide for their own food, clothing, or shelter. 1. According to a complaint filed to the CDPH, L&C Program, the facility discharged Resident 1, a conservatee of the Orange County Public Guardian's Office, to an unlicensed facility without the authorization of the public guardian. The Deputy Public Guardian (Resident 1's conservator) stated Resident 1 was unsafely discharged and was basically dumped by the facility on [DATE]. Resident 1 had multiple acute psychiatric hospitalization s in the last year and was deemed gravely disabled by the Superior Court of California. Resident 1 required a structured and supervised environment and needed assistance with her ADL care. Resident 1 was very uncooperative with her treatment and continued to need behavioral management. Resident 1 can be easily taken advantage of and was vulnerable if left on her own. Closed medical record review for Resident 1 was initiated on 3/4/2020. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of the MDSs dated 1/21 and [DATE], showed Resident 1 had moderate cognitive impairment. Review of the Assessment for Self-Administration of Medications dated 1/15/2020, showed Resident 1 was unable to read the medication label, unable to correctly state what the medications were for, unable to correctly state how much medication to take for each dose, unable to correctly administer medications, and unable to correctly state the situations for the administration of PRN (as needed) doses. Review of the Elopement Risk assessment dated [DATE], showed Resident 1 was at risk for potential elopement from the facility. Review of Resident 1's plan of care showed a care plan problem dated 1/16/2020, to address discharge planning. Resident 1 was expected to be discharged to another nursing home or psychiatric facility. The plan was to review and discuss the discharge plans with the resident/responsible party as appropriate. Another care plan problem dated 1/23/2020, to address Resident 1's risk for injuries secondary to elopement showed Resident 1 required a WanderGuard (security device) to enhance safety. (The WanderGuard is a wrist or ankle transmitter worn by the resident where the system will sound an alarm when a door system (usually at door or hallway locations that are deemed likely routes of escape and will need monitoring) reads a resident transmitter. This helps prevent an elopement as staff can be notified by alarms at the door.) Review of the Physician order [REDACTED]. Review of the Notice of Transfer/discharge date d [DATE], signed by the facility's representative on [DATE], showed Resident 1's transfer or discharge was appropriate because her health had improved sufficiently so that she no longer required the services provided by the facility. However, review of Resident 1's medical records failed to show Resident 1 was assessed by the physician and the physician had documented whether Resident 1's transfer or discharge was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet Resident 1's needs. Review of Resident 1's medical records showed Resident 1 was last seen and examined by the physician on 2/3/2020, as documented on the Physician's Progress Notes. The Physician's Progress Notes showed Resident 1 was seen and examined at the bedside and a review of the systems (a systematic list of questions arranged by organ systems used to aid clinicians to uncover clinical problems) was unchanged. The physician's documented assessment and plan showed Resident 1 had [MEDICAL CONDITION] and to continue [MEDICATION NAME] ([MEDICAL CONDITION] medication), lack of coordination and to continue occupational and physical therapy rehabilitation, and [MEDICAL CONDITION] to continue with support care. Review of the Social Service Notes dated [DATE], showed the facility was unable to contact the Deputy Public Guardian; however, Resident 1 was transferred to Room and Board Facility A as the facility continued to attempt to contact the Deputy Public Guardian. Review of the Physician's Discharge Summary (undated) showed Resident 1 was discharged to Room and Board A on [DATE]. The summary showed the transfer/discharge was necessary due to the resident's health had improved sufficiently and no longer needed the services provided by the facility. There was no physician's signature on the summary. On 3/4/2020 at 1109 hours, an interview and concurrent closed medical record review was conducted with the Medical Records Director and the Medical Records Assistant. The Medical Records Assistant verified he filled out the Physician's Discharge Summary and marked the box showing the transfer/discharge was necessary due to the resident's health had improved sufficiently and no longer needed the services provided by the facility. The Medical Records Director verified Resident 1's Physician's Discharge Summary was not completed nor signed by the physician. On 3/4/2020 at 1119 hours, an interview and concurrent closed medical record review was conducted with SSD 1. SSD 1 was asked about the process for transferring or discharging residents to a lower level of care. SSD 1 stated, upon admission, a discharge plan was developed to identify whether the resident was to return to the previous living arrangement or to a lower level of care. SSD 1 stated discharge planning was supposed to be discussed with the resident's responsible party. SSD 1 verified Resident 1 had a conservator that made all financial and health-related decisions for Resident 1, as Resident 1 was not legally able to make her own

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) decisions. SSD 1 verified the Deputy Public Guardian was not notified of or authorized Resident 1's transfer to the lower level of care. SSD 1 stated Resident 1 was transferred to Room and Board A without prior notification and authorization from the Deputy Public Guardian because Room and Board Facility A would not hold the bed for Resident 1. On 3/4/2020 at 1218 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the above medical record review findings for Resident 1. The DON stated Resident 1 was discharged to a lower level of care because her condition improved. The DON was asked about the process for transferring or discharging residents to a lower level of care. The DON stated the resident's plan of care identified if the resident might remain at the facility long term, return to the community, or be discharged to a lower level of care. The DON verified Resident 1's care plan problem to address discharge planning showed Resident 1 was expected to be discharged to another nursing home or psychiatric facility. The DON verified there was no documentation to show the physician had assessed Resident 1 to determine whether the transfer or discharge was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet Resident 1's needs. The DON verified Resident 1 was last examined by the physician on 2/3/2020, and the physician documented Resident 1's condition was unchanged and required continued occupational and physical therapy rehabilitation and support care. On 3/5/2020 at 0851 hours, a telephone interview was conducted with the Deputy Public Guardian. The Deputy Public Guardian stated Resident 1 was deemed gravely disabled due to mental illness and was under the public guardian's conservatorship. The Deputy Public Guardian stated Resident 1 had resided at a different skilled nursing facility (SNF) since 2018 and required placement at a SNF or TRC (therapeutic residential care facility, a live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems) because Resident 1 had suicidal ideation, coping skills, and people skills requiring supervision and therapy. The Deputy Public Guardian stated the facility transferred Resident 1 to an unlicensed and unsupervised environment without first notifying her and without her authorization. The Deputy Public Guardian stated Resident 1 required her medications to be administered to her as she could not administer her own medications and was not at a high enough functional level to be transferred to Room and Board Facility A. The Deputy Public Guardian stated Resident 1 eloped from Room and Board Facility A due to the lack of supervision and was still not found. The Deputy Public Guardian stated Resident 1's file showed no documentation the facility had notified her or her office of plans to transfer Resident 1 to Room and Board Facility A. On 3/6/2020 at 1108 hours, a telephone interview was conducted with the House Manager (of Room and Board Facility A). The House Manager stated Resident 1 eloped for several days and was found last night (3/5/2020). The House Manager was asked about Resident 1's condition when she was found. The House Manager stated when Resident 1 arrived back to the room and board facility, her feet, hands, and clothing were very dirty like she had been walking down the street for a while without shoes and socks on. The House Manager stated Resident 1 was distraught when she arrived back at the facility. When asked to elaborate, the House Manager stated Resident 1 was frightened, scared, and did not know where she was at. The House Manager stated Resident 1 closed up on him when he asked her where she had been. On 3/6/2020 at 1108 hours, a telephone interview was conducted with the owner of Room and Board Facility A. The Owner of Room and Board Facility A stated the room and board facility was an unlicensed single-family home that did not provide medical services. The owner of Room and Board Facility A stated there were no CNAs to provide ADL care or nurses to administer medications. The owner of Room and Board Facility A stated the residents who resided at the room and board facility had to be able to ambulate, provide their own ADL care, and administer their own medications. The owner of Room and Board Facility A stated a nurse did not come to administer Resident 1's medications because all home health visits had to be arranged with him (the owner of Room and Board Facility A). The owner of Room and Board Facility A verified Resident 1 eloped and was missing for six days before the police found her in the parking lot of a different city. The owner of Room and Board Facility A stated Resident 1 was worn, tired, and dehydrated when she was found. The owner of Room and Board Facility A stated Resident 1 did not say where she was while she was missing or why she left. On 3/6/2020 at 1340 hours, a follow-up telephone interview was conducted with the owner of Room and Board Facility A. The owner of Room and Board Facility A stated Resident 1 was dehydrated because she was really thirsty and her lips and mouth were really dry. The owner of Room and Board Facility A stated he did not seek medical care for Resident 1 because the officers who found Resident 1 would have said if she needed medical care. On 3/10/2020 at 1428 hours, a follow-up telephone interview was conducted with the House Manager. The House Manager stated Resident 1 eloped from the Room and Board again yesterday ([DATE]20). The House Manager stated Resident 1 was ranting, talking to herself, and had aggressive behavior exhibited through her tone and body language before she eloped. The House Manager stated Resident 1 was still missing. On 3/11/2020 at 1026 hours, an interview was conducted with RN 1. RN 1 stated Resident 1 had behaviors of constantly pacing and walking around the facility and had exit-seeking behavior. RN 1 stated Resident 1 required the WanderGuard because of her exit-seeking behavior. RN 1 stated she remembered at least one occasion where Resident 1 attempted to elope from the facility, but the WanderGuard alarmed and alerted the staff to stop her from eloping. Cross reference to F623, example #1. 2. Closed medical record review for Resident 2 was initiated on 3/4/2020. Resident 2 was admitted to the facility on [DATE], and was discharged on [DATE]. Review of the Assessment for Self-Administration of Medications dated 10/18/19, showed Resident 2 was unable to correctly administer medications. Review of the Discharge Planning assessment dated [DATE], showed Resident 2 was anticipated to be discharged to a board and care facility (a residential home licensed to provide care and supervision to their residents) or assisted living facility. Review of the Physician order [REDACTED]. Review of the Notice of Transfer/discharge date d [DATE], signed by the facility's representative on [DATE], showed Resident 2's transfer or discharge was appropriate because her health had improved sufficiently so that she no longer required services provided by the facility. However, review of Resident 2's medical records failed to show Resident 2 was assessed by the physician nor the physician had documented whether Resident 2's transfer or discharge was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet Resident 2's needs. Review of Resident 2's Physician's Progress Notes showed Resident 2 was last seen and examined by the physician on 1/7/2020, and was last seen and examined by the nurse practitioner on 1/13/2020. Neither entries showed Resident 2's health had improved sufficiently to ensure the lower level of care could safely meet Resident 2's needs. Review of the Discharge Summary/Comprehensive assessment dated [DATE], showed Resident 2 was incontinent of bowel and bladder and required assistance with bathing, dressing, personal hygiene, transfers, bed mobility, toilet use, and ambulation. Review of the MDS dated [DATE], showed Resident 2 required extensive assistance from one staff member for bed mobility (how the resident moved to and from a lying position, turned side to side, and positioned her body while in bed), transfers (how the resident moved between surfaces including to or from the bed, chair, wheelchair, or standing position), and dressing; and was totally dependent on the staff for locomotion on the unit (how the resident moved between locations in her room and adjacent corridor; if in the wheelchair, self-sufficiency once in the chair), toilet use, personal hygiene, and bathing. Review of Resident 2's discharge MDS dated [DATE], showed Resident 2 required extensive assistance for bed mobility, transfers, locomotion off the unit (how the resident moved to and returned from off-unit locations such as areas set aside for dining, activities, or treatment), dressing, toilet use, personal hygiene, and bathing. On 3/4/2020 at 1235 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above medical record review findings for Resident 2. The DON stated Resident 2 was discharged to a lower level of care because her condition improved. The DON verified there was no documentation to show the physician had assessed Resident 2 to determine whether the transfer or discharge was appropriate and the resident's health had improved sufficiently to ensure the lower level of care could safely meet Resident 2's needs. The DON verified Resident 2 still required extensive assistance for most of her ADLs including bed mobility, transfers, dressing, toileting, personal hygiene, and bathing at the time of her of her discharge. The DON stated Resident 2 could self-propel herself in her wheelchair, but could not ambulate without assistance from the staff. On 3/10/2020 at 1045 hours, a telephone interview was conducted with the Owner of Room and Board A. The Owner of Room and Board A stated Resident 2 was not currently and had never resided at Room and Board A. On 3/10/2020 at 1127 hours, a telephone interview was conducted with SSD 1. SSD 1 stated on the day Resident 2 was transferred, Room and Board Facility A called the facility to notify them that Room and Board Facility A could not accommodate Resident 2 at the room and board facility because they did not have a wheelchair ramp. SSD 1 stated SSD 2 arranged for Resident 2 to be transferred to a different facility from Room and Board Facility A. On 3/10/2020 at 1132 hours, a telephone interview was conducted with SSD 2. SSD 2 stated after Resident 2 was transferred to Room and Board Facility A, Room and Board Facility A notified the facility on the same day that the Room and Board Facility A could not accommodate a resident who was wheelchair bound because the Room and Board Facility A did not have a wheelchair ramp. SSD 2 stated she and SSD 1 then arranged for Resident 2 to be transported and transferred from Room and Board Facility A to Room and Board Facility B. On 3/10/2020 at 1303 hours, a telephone interview was conducted with the owner of

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F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Room and Board Facility B. The owner of Room and Board Facility B stated the house was an unlicensed room and board facility where they rented out a room, or part of the room in the house. The owner of Room and Board Facility B stated they did not provide medical services and the residents who lived there had to be able to provide care for themselves. The owner of Room and Board Facility B elaborated by stating the residents had to be able to take their own medications and be able to take themselves to the bathroom. The owner of Room and Board Facility B stated they could not take Resident 2, and Resident 2 left that same day because she was wheelchair bound and could not even walk. The Owner of Room and Board B stated they found Resident 2 sitting in her wheelchair in the Room and Board 's front yard crying and scared. The owner of Room and Board Facility B stated the driver had just left Resident 2 there. The owner of Room and Board Facility B stated Resident 2 was transported to the local emergency department via 911. On 3/11/2020 at 1153 hours, an interview was conducted with LVN 1. LVN 1 stated he was familiar with Resident 2. LVN 1 stated Resident 2 required extensive assistance upon admission and upon discharge from one to two staff members for most ADLs. LVN 1 stated Resident 2's level of ADL assistance needed did not change much upon discharge. LVN 1 stated Resident 2 could not ambulate without assistance. Review of the acute care hospital's documentation titled Order for Inpatient Social Services Consult dated 2/21/2020, showed the reasons for the consultation were financial issues (including transportation) and homelessness and support systems (community resources/caregiver issues). Resident 2 had a history of [REDACTED]. Resident 2 was also kicked out of her board and care due to financial reasons and needed safe discharge placement. Review of the acute care hospital's documentation titled Social Services Screening/Brief Intervention dated 2/21/2020, showed the acute care hospital's social worker contacted the Owner of Room and Board B and was informed that the room and board did not accept Resident 2 at the room and board. The documentation showed the Owner of Room and Board B stated that Resident 2 was sent to her home without communicating with her (the Owner of Room and Board B) about the resident's physical limitations. The Owner of Room and Board B stated that her home was a transitional living and did not provide any support other than meals. The documentation further showed the owner of Room and Board Facility B stated some man dropped Resident 2 off at her home and she just showed up on her lawn. Cross reference to F623, example #2.
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 medical record review, the facility failed to notify the residents and their representatives of the transfer or discharge and the reasons for the move in writing and failed to send a copy of the notice of transfer/discharge to the representative of the Office of the State Long-Term Care Ombudsman for two of four closed record sampled residents (Residents 1 and 2). * Resident 1, a conservatee of the Orange County Public Guardian's Office, was transferred to an unlicensed room and board facility without the notification or authorization of the Deputy Public Guardian, in writing or otherwise. This failure resulted in Resident 1 being transferred to a Room and Board that could not meet her care needs, where Resident 1 eloped from. Resident 1's whereabouts was still unknown as of 3/10/2020. * The facility failed to send a copy of the notice of transfer/discharge to the representative of the Office of the State Long-Term Care Ombudsman for Residents 1 and 2. This posed the risk of the Ombudsman not being aware of the circumstances of the residents' transfers/discharges should an appeal be filed by the residents or their representatives regarding the transfers. Findings: According to the Orange County Health Care Agency, Room and Board facilities are not licensed to provide care and supervision to their residents. Residents are expected to manage their medications, transportation, and other needs on their own. According to the Orange County Health Care Agency, the Public Guardian serves the community by providing investigative and fiduciary services to adults who are unable to provide their own basic personal needs due to a severe mental disorder or disabling physical condition. The Superior Court determines whether a conservatorship should be established. Conservatorship referral criteria includes grave disability due to a mental disorder and being unable to provide for their own food, clothing, or shelter. 1. According to a complaint filed with the CDPH, L&C Program, the facility discharged Resident 1, a conservatee of the Orange County Public Guardian's Office, to an unlicensed facility without the authorization of the public guardian. The Deputy Public Guardian (Resident 1's conservator) stated Resident 1 was unsafely discharged and was basically dumped by the facility on [DATE]. Closed medical record review for Resident 1 was initiated on 3/4/2020. Resident 1 was admitted to the facility on [DATE], and was discharged on [DATE]. Review of the Notice of Transfer/discharge date d [DATE], signed by the facility's representative on [DATE], showed Resident 1's transfer or discharge was appropriate because her health had improved sufficiently so that she no longer required services provided by the facility. There was an illegible mark that resembled the letter E in the section for the resident representative's signature. The section to document the date a copy of the notice was sent to the Ombudsman was blank. The Notice of Transfer/Discharge showed If you believe that the proposed transfer/discharge is inappropriate in your case, and is involuntary, you have the right to appeal. The appeal can be filed in writing to, or by calling the following: DHCS Office of Admin Hearing & Appeals, State LTC Ombudsman Office, State Agency for the Developmentally Disabled, and/or the State Agency for the Mentally Ill. The notice further showed if the resident or their representative intended to appeal, it was important to do so within 10 calendar days of being notified. On 3/4/2020 at 1218 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 1 had a conservator who made all healthcare decisions for Resident 1, including transfers and discharges. The DON stated the Notice of Transfer/Discharge was to be provided to the resident's representative prior to transferring or discharging the resident. The DON verified there was no documentation to show the Deputy Public Guardian was notified of or authorized Resident 1's transfer to Room and Board A. The DON verified there was no documentation or fax confirmation to show a copy of the notice was sent to the office of the ombudsman. On 3/4/2020 at 1240 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 verified she completed the Notice of Transfer/discharge date d [DATE], for Resident 1. RN 1 verified the notice was not provided to Resident 1's representative, the Deputy Public Guardian. RN 1 verified the Deputy Public Guardian did not sign the Notice of Transfer/Discharge. RN 1 stated the notice was signed by the transportation driver who transported Resident 1 to Room and Board A. On 3/5/2020 at 0851 hours, a telephone interview was conducted with the Deputy Public Guardian. The Deputy Public Guardian stated Resident 1 was deemed gravely disabled due to mental illness and was under the public guardian's conservatorship. The Deputy Public Guardian stated Resident 1 had resided at a different skilled nursing facility (SNF) since 2018 and required placement at a SNF or TRC (therapeutic residential care facility, a live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems) because Resident 1 had suicidal ideation, coping skills, and people skills requiring supervision and therapy. The Deputy Public Guardian stated the facility transferred Resident 1 to an unlicensed and unsupervised environment without first notifying her and without her authorization. The Deputy Public Guardian stated the facility never discussed plans to transfer Resident 1 to Room and Board A with her or her office. Cross reference to F622, example #1. 2. Closed medical record review for Resident 2 was initiated on 3/4/2020. Resident 2 was admitted to the facility on [DATE], and was discharged on [DATE]. Review of the Physician order [REDACTED]. Review of the Notice of Transfer/discharge date d [DATE], signed by the facility's representative on [DATE], showed Resident 2's transfer or discharge was appropriate because her health had improved sufficiently so that she no longer required services provided by the facility. The section to document the date a copy of the notice was sent to the ombudsman was blank. On 3/4/2020 at 1235 hours an interview and concurrent medical record review was conducted with the DON. The DON verified there was no documentation or fax confirmation to show a copy of the notice was sent to the ombudsman. On 3/6/2020 at 1545 hours, a telephone interview was conducted with the LTC Ombudsman. The LTC Ombudsman stated the facility was supposed to discuss safe discharge placement with the residents' representatives and provide them with the Notice of Transfer/Discharge. The LTC Ombudsman stated the notice tells the residents and their representatives of their right to appeal and how to appeal the transfer/discharge. The LTC Ombudsman stated she would act as an advocate if a resident appealed their transfer/discharge. After checking her files and messages, the LTC Ombudsman verified she did not receive copies of the Notice of Transfer/Discharge for Residents 1 and 2. Cross reference to F622, example #2.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.**

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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 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure two of four closed record sampled residents (Residents 1 and 2) were provided discharge instructions in a language and manner that was easily understood. Residents 1 and 2's written discharge instructions for their medications were not provided in layman's terminology, but contained medical abbreviations and terminology. This had the potential to impair Residents 1 and 2's disease management and placed them at risk to experience adverse reactions from their medications should they not understand the instructions. Findings: According to the Orange County Health Care Agency, room and board facilities are not licensed to provide care and supervision to their residents. Residents are expected to manage their medication, transportation, and other needs on their own. According to the Orange County Health Care Agency, the Public Guardian serves the community by providing investigative and fiduciary services to adults who are unable to provide their own basic personal needs due to a severe mental disorder or disabling physical condition. The Superior Court determines whether a conservatorship should be established. Conservatorship referral criteria includes grave disability due to a mental disorder and being unable to provide for their own food, clothing, or shelter. 1. Closed medical record review for Resident 1 was initiated on 3/4/2020. Resident 1 was admitted to the facility on [DATE], and was discharged on [DATE]. Review of the Physician order [REDACTED]. Review of Resident 1's Post Discharge Plan of Care dated [DATE], showed Resident 1's written discharge instructions for her medications were not provided in layman's terminology and contained medical abbreviations and terminologies. Resident 1 was discharged to the room and board facility with nine medications that showed the dosages, route and frequency at which to take the medications, and special instructions were all provided in medical abbreviations and terminologies. For example, the first medication showed: [MEDICATION NAME] 5 mg tablet - 1 tab PO QD for HTN. Hold if SBP <110 or HR <60. On 3/4/2020 at 1218 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated written discharge instructions for medications were to be documented on the Post Discharge Plan of Care and were supposed to be written in layman's terminology so the residents could understand the instructions. The DON verified Resident 1's written discharge instructions for her medications were not provided in layman's terminology. On 3/5/2020 at 0851 hours, a telephone interview was conducted with the Deputy Public Guardian (Resident 1's conservator). The Deputy Public Guardian stated Resident 1 was under conservatorship because she was deemed gravely disabled due to mental illness. The Deputy Public Guardian stated Resident 1 could not administer her own medications and required her medications to be administered to her. On 3/6/2020 at 1125 hours, a telephone interview was conducted with the Owner of Room and Board A. The Owner of Room and Board A stated the facility was unlicensed and did not provide medical services. The Owner of Room and Board A stated there was no nursing services to administer Resident 1's medications. The Owner of Room and Board A stated Resident 1 had to administer her own medications. 2. Closed medical record review for Resident 2 was initiated on 3/4/2020. Resident 2 was admitted to the facility on [DATE], and was discharged on [DATE]. Review of the Physician order [REDACTED]. Review of Resident 2's Post Discharge Plan of Care dated [DATE], showed Resident 2's written discharge instructions for her medications were not provided in layman's terminology and contained medical abbreviations and terminologies. Resident 2 was discharged to the room and board facility with 20 medications that showed the dosages, route and frequency at which to take the medications, and special instructions were all provided in medical abbreviations and terminologies. For example, the first medication showed: [MEDICATION NAME] 25 mg - 1 tab PO every 8 hours PRN for headache. On 3/4/2020 at 1235 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the above findings.