STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185176	A. Building B. Wing	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Oaks Care and Rehab Center, LLC	446 Mt. Holly Avenue Louisville, KY 40206

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42857 Based on interview, record review and review of the facility's policy, it was determined the facility failed to protect residents from neglect by failing to provide the necessary goods and services for one (1) of nine (9) sampled residents (Resident #2). The facility admitted Resident #2 at approximately 12:15 PM on 04/17/2021. Staff entered Resident #2's information into the facility's Electronic Health Record (EHR) at 2:05 PM. However, Resident #2's Physician's Orders including medication orders were not entered in the EHR until 5:00 PM to 6:08 PM, five (5) to six (6) hours after admission. Resident #2's diagnoses included Diabetes; however, the facility failed to obtain an order to monitor the resident's blood glucose levels, and failed to administer his/her ordered insulin. The facility failed to document completion of Resident #2's admission assessments. Resident #2 requested to return to the hospital due to unrelieved abdominal pain on 04/18/2021 at 12:40 AM, approximately twelve (12) hours after his/her admission. The hospital admitted Resident #2 with a diagnosis of Respiratory Failure with a decreased oxygen saturation (O2 sat) level of 89% which required oxygen therapy. Resident #2 was also diagnosed with bilateral Pleural Effusions (excessive fluid build up around the lung) and Dyspnea (shortness of breath). The facility's failure to take immediate action to prevent neglect and to follow their policy to ensure all residents were free from neglect has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/13/2021 and was determined to exist on 04/17/2021. Immediate Jeopardy was determined to exist at CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), CFR 483.25 Quality of Care (F697). The facility was notified of the Immediate Jeopardy on 09/13/2021. The facility submitted an acceptable Allegation of Compliance (AOC) on 09/17/2021 and alleged removal of immediacy on 09/17/2021. The State Survey Agency validated removal of the Immediate Jeopardy, before exit, on 09/17/2021, as alleged. The findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy entitled, Freedom from Abuse and Neglect, dated 10/30/2019, revealed the definition of neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional stress. Further review revealed the facility was to conduct an investigation of any alleged abuse or neglect and would notify the proper authorities. Review of the facility's policy, Resident Rights, revised 12/2016, revealed federal and state laws guaranteed certain basic rights for all residents residing in the facility. The rights included: being treated with respect, kindness and dignity; remaining free from abuse, neglect, misappropriation of property and exploitation; and having equal access to quality care, regardless of the source of payment. 1. Review of Resident #2's medical record revealed the facility admitted the resident on 04/17/2021, with diagnoses which included Sepsis, Hypertension, Type 2 Diabetes Mellitus, Cellulitis of Buttock, and Cutaneous Abscess of Buttock. Continued review revealed no documented evidence of completed admission paperwork; transportation documentation; completed laboratory (labs) documentation; a dietary slip which noted the resident's diet orders; or of assessments completed upon admission. Further review also revealed no documented evidence of staff's monitoring of Resident #2's oral food and fluid intake. Review of the facility's Current Weight and Vitals, documentation for Resident #2 dated 04/17/2021, revealed no documented evidence staff obtained the resident's height, weight, respirations, temperature, blood glucose level, oxygen saturation level or pain level after his/her admission to the facility. Continued review revealed Certified Medication Technician (CMT) #1 documented that she had obtained Resident #2's blood pressure and heart rate at 9:54 PM, approximately ten (10) hours after the resident's arrival at the facility. Review of Resident #2's Physician's Orders dated 04/17/2021, revealed the resident's orders were entered into the facility's EHR by Registered Nurse (RN) #1 between 5:00 PM and 6:08 PM, approximately five (5) to six (6) hours after the resident's admission. Continued review revealed the Physician had prescribed medications for Resident #2 which included medications for hypertension, pain, intravenous (IV) antibiotics; and, insulin which was to be administered at bedtime. Per review, there was no documented evidence of orders for monitoring Resident #2's blood glucose monitoring, nor an order for the resident's blood glucose parameters. Further review revealed no documented evidence of orders for admission labs; or to monitor Resident #2 for signs and symptoms of hyperglycemia or hypoglycemia (high and low blood glucose levels). Review of Resident #2's Medication Administration Record (MAR), dated 04/2021, revealed no documented evidence the facility administered the resident's ordered Hydrocodone-Acetaminophen (pain medication) 10 milligram - 325 milligram (mg) every four (4) hours for pain as needed, Insulin Glargine (diabetic insulin) sixty-five (65) units subcutaneously at bedtime, and Daptomycin (intravenous antibiotic) four hundred (400) mg one time a day for Cellulitis and abscess of the buttock. Further review revealed Resident #2 missed three (3) potential administrations of pain medication, one scheduled administration of insulin and one scheduled administration of his/her intravenous antibiotic. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's Progress Notes revealed a late entry note completed by Licensed Practical Nurse (LPN) #1, on 04/21/2021, dated 04/17/2021 which noted the resident arrived at the facility at approximately 12:15 PM. Continued review of the Progress Notes revealed another late entry note, on 04/21/2021 completed by Registered Nurse (RN) #1, for the date of 04/17/2021 at 12:32 PM, which documented Resident #2's vital signs had been obtained, and noted the resident was oriented to his/her new room. Per review of RN #1's late entry note, Resident #2 was provided a lunch tray per the diet ordered, and the orders had been verified with the Physician. Interview with Resident #2 on 09/02/2021 at 11:54 AM, revealed he/she arrived at the facility around 12:00 PM on 04/17/2021, via ambulance. Resident #2 stated he/she was in the facility for approximately five (5) or six (6) hours, and did not see or hear from any of the staff. Resident #2 stated that he/she walked up the hallway to the Nurse's Station after the five (5) to six (6) hour interval to speak to the staff person sitting at the desk. The resident stated the staff person told him/her they were unaware that he/she (Resident #2) had been admitted as that information had not been given to her during shift report. Continued interview revealed Resident #2 requested pain medication from the staff person, who was the night shift nurse. However, the resident stated that he/she did not receive the pain medication after requesting it, and did not receive the ordered antibiotic while in the facility. Resident #2 stated the night shift nurse told him/her the pain medication ordered would not be delivered to the facility until 04/18/2021 around 2:00 AM. According to Resident #2, he/she had experienced several surgeries to his/her buttock related to the abscess and infection. Resident #2 stated the surgical areas on his/her buttock caused him/her a lot of pain when doing pretty much anything, like walking, sitting, lying down, or using the bathroom. Further interview revealed Resident #2 was an insulin dependent diabetic and no one had checked his/her blood glucose level, or administered his/her ordered insulin. Resident #2 stated he/she requested to be sent back to hospital when he/she experienced abdominal pain. Resident #2 further revealed he/she returned to the hospital after being in the facility for approximately twelve (12) hours. Additionally, Resident #2 stated while in the hospital's Emergency Department (ED), staff administered the IV antibiotic which he/she had missed while residing at the facility. Review of the hospital's documentation for Resident #2 dated 04/18/2021, revealed the resident had reported to ED staff that he/she requested to leave the facility to return to the hospital. Per review, Resident #2 was admitted to the hospital and diagnosed with Respiratory Failure, Dyspnea, and bilateral Pleural Effusions. Further review revealed Resident #2 had an oxygen saturation level of 89% (below 90 percent was considered to be low blood oxygen also known as hypoxemia) and required oxygen therapy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #2, on 09/07/2021 at 10:03 AM, revealed she was the 7:00 PM to 7:00 AM (night shift) nurse who took over Resident #2's care from LPN #1 on 04/17/2021. Per interview, LPN #2 had not received information on Resident #2 being a new admission, in the shift exchange report she received from LPN #1. She stated she only became aware of Resident #2's presence when she started passing medications to other residents, and noticed the resident's call light kept coming on. LPN #2 stated she entered Resident #2's room to see if she could help the resident with anything, and the resident's main focus was pain and not having received the requested pain medication. Interview with LPN #2 revealed she was unaware Resident #2 requested pain medication previously and LPN #2 was unable to identify the staff member to whom Resident #2 spoke. According to LPN #2, Resident #2 told her that he/she would leave the facility Against Medical Advice (AMA) if his/her pain medication wasn't administered soon. Continued interview revealed Resident #2 told her he/she had been in the facility for several hours with no assistance from staff. LPN #2 stated that no one had reported to her that Resident #2 was a diabetic, who was insulin dependent and required glucose monitoring and insulin administration. Per the LPN, during her shift on 04/17/2021, there had been no documentation for her to review such as Progress Notes which noted the previous staff had assisted Resident #2, or attempted to complete the admission requirements for him/her. The LPN stated if Resident #2 had required monitoring for some reason, like blood sugars, it should have populated on the resident's MAR (Medication Administration Record) if the orders had been entered into the facility's EHR. LPN #2 also stated once she was aware of Resident #2 being a new resident, her main concern was trying to manage the resident's apparent pain. Interview revealed LPN #2 notified the Director of Nursing (DON) of Resident #2's concerns regarding having no assistance from staff after hours in the facility, and of the resident not receiving any pain medication. The LPN stated the DON directed her to call the Pharmacy to confirm when Resident #2's medications were to be delivered to the facility. Further interview revealed she was unable to explain what had happened with Resident #2's admission. She stated; however, when she received a new resident for admission she went to the resident's room as soon as possible to meet him/her and do the admission inventory list. Per interview, she also ensured the new resident's bedside was set up with the things he/she might need. LPN #2 further stated she also completed a skin assessment of newly admitted residents assigned to her as anything could happen during the transfer to the facility. The State Survey Agency Surveyor attempted telephone (phone) contact with Licensed Practical Nurse (LPN) #1, and Certified Nurse Assistant (CNA) #1, who were assigned to Resident #2's care on the 7:00 AM to 7:00 PM, on the day of admission. However, all phone contact attempts were unsuccessful. Interview with the Executive Director on 09/10/2021 at 1:15 PM, revealed LPN #1 and CNA #1 were no longer employed by the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #1, on 09/07/2021 at 9:44 AM, revealed when she received a new admission she went to the resident's room to introduce herself, and obtain his/her vital signs for a baseline. Per interview, RN #1 completed a skin assessment, and ensured a meal was provided or needed for a resident who had missed a meal. Continued interview revealed it was important to see a new resident as soon as possible after they arrived to ensure the person was in a stable condition. She stated if staff didn't do that in a timely fashion and establish a baseline, the facility would not be aware if the resident experienced a change in his/her status. Further interview with RN #1 revealed she could not recall Resident #2 specifically or if she assisted with his/her admission. Per the RN, if she had not been assigned to Resident #2's care, and had been the one who entered the Physician's Orders in the EHR, she must have been assisting LPN #1 with the admission. Additionally, RN #1 could not recall why she completed a late entry progress note four (4) days after the resident was admitted to the facility. Interview with LPN #3, on 09/10/2021 at 9:59 AM, revealed when she was assigned a new admission she went to meet the resident as soon as possible to obtain his/her vital signs and perform skin and/or wound assessments of the resident. She stated it was important for staff to ensure all assessments and any concerns noted were documented on admission in order for them to be addressed. Continued interview revealed it was very important to ensure all orders were entered into the resident's EHR as quickly as possible so the pharmacy could be working on filling the new resident's prescriptions and deliver them to the facility. Additionally, she revealed if a facility resident did not receive the care and services they needed it could be considered neglect, which was unacceptable. Interview with RN #3, on 09/10/2021 at 9:48 AM, revealed when she was assigned a new resident's admission, she went to their room as soon as she could to meet them, complete their vital signs and perform a skin assessment to establish their baseline information. Per interview, she stated she did this so that she and other staff could monitor the new resident for any change of status. RN #3 stated she also sent the new resident's medication orders to pharmacy as quickly as they were available to prevent the resident from missing any doses. Further interview revealed if she or other nursing staff failed to complete all of the admission tasks in a timely manner, and the new resident missed his/her medications, the facility did not provide the resident's required care and services. RN #3 further revealed that could be considered neglect of the new resident. Interview with the Nurse Practitioner (NP), 09/09/2021 at 9:00 AM, revealed she was on call for the Medical Director twenty-four (24) hours a day seven (7) days a week. She stated she recalled being notified when Resident #2 arrived at the facility, and recalled verifying the Physician's Orders with the nurse. Continued interview revealed she had ordered labs for Resident #2 which included a Comprehensive Metabolic Panel, Complete Blood Count, and a Hemoglobin A1C (measures average blood glucose over a 3 month period). Per interview, she would have came to the facility on [DATE], to see Resident #2 if he/she had not been sent out to the hospital. Continued interview revealed staff should have entered a Physician's Order to monitor Resident #2's blood glucose before meals and at bedtime. She stated if the facility had not been monitoring Resident #2's blood glucose while he/she was there, and the resident's blood sugar had dropped there could have been issues for the resident. Further interview with the NP revealed she had received a phone call on 04/18/2021 around 1:00 AM, from facility staff requesting Resident #2 be sent back to the hospital per the resident's request. She further stated staff should always contact her as soon as possible after a new resident was admitted to ensure the new resident was prescribed the correct medications and if changes were necessary they could be done. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's previous Director of Nursing (DON), on 09/13/2021 at 9:50 AM, revealed she was unable to recall Resident #2's admission to the facility, or any identified concerns regarding the resident's admission. The DON stated when a new resident was admitted the Physician was to be notified to verify the new resident's orders. Continued interview revealed nursing staff was to send the verified orders for the medications and/or treatment medications to the Pharmacy as quickly as possible in order for Pharmacy staff to fill the prescriptions and get them to the facility. She stated the nurse assigned to the newly admitted resident was responsible for ensuring all those things were completed in a timely manner. Further interview revealed on the next business day following new residents' admissions, facility staff reviewed all the admissions to ensure the completeness of the admission information. The previous DON stated it was up to the assigned nurse's judgement to determine what things on the new admission checklist for a new resident needed to be completed timely. Interview with the acting DON, on 09/10/2021 at 1:47 PM, revealed she was hired in August 2021. She stated when new residents were admitted the nurse assigned was provided with a new admission checklist. The new admission checklist was completed to ensure all aspects of a new resident's admission were completed. Per review, staff in the facility's clinical meeting also reviewed the new resident's admission information as a backup to ensure everything was completed as per policy. She stated things such as vital signs, skin assessments and Physician's Order's entry were to be completed as timely as possible. Continued interview revealed those things were done to gather a baseline for the new resident and to assess his/her current needs. The DON stated if those things were not completed timely, staff would not be aware of the new resident's needs. Further interview revealed the facility had identified concerns with admissions and was currently reevaluating the new admission checklist, and how their EHR system triggered when assessments were due. In addition, she revealed the concerns regarding the facility's admission process would be taken to their Quality Assurance Performance Improvement (QAPI) meetings for review. Interview with the previous ED, on 09/10/2021 at 1:31 PM, revealed when a nurse received a new resident for admission she expected the nurse to meet the resident, and ensure all the assessments were completed within twenty-four (24) hours. Per interview, she expected the nurses to ensure the Physician was notified to verify the new resident's medication orders, and make sure the orders were sent to the Pharmacy in a timely manner. The previous ED stated she had not identified any concerns with the facility's admission process. Further interview revealed the facility had processes in place to ensure new residents received their medications without missing doses. She further revealed staff were expected to follow the processes to ensure new residents received the goods and services they needed. Interview with the current ED, on 09/10/2021 at 1:15 PM, revealed she had been hired at the facility for three (3) weeks. Per interview, she expected facility staff to follow the admission policy and complete the admission checklist within the given time frame. Per interview, she also expected staff to make the proper notifications to the Provider to ensure new residents' goods and services were being administered as required. The facility alleged it implemented the following actions to remove immediacy: 1. Resident #2 no longer resides in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The ED and DON, notified the Physician of the event, and held an ADHOC QAPI meeting on 09/13/2021, to discuss the event and discussion of developing an action plan to address the event. 3. The DON conducted an audit of resident admissions for the past thirty (30) days, starting on 09/08/2021, to determine if assessments were completed and to ensure orders were reviewed and verified along with ensuring medications were available. 4. The DON, ADON, UM, and/or the VPCS were to reeducate all licensed staff, including agency staff, on or before 09/16/2021, regarding the following: admission policy; order verifications; admission assessments; and the process for obtaining medications from the pharmacy, including a posttest. Staff not available were to be reeducated on return to work and new hires were to be provided the education during orientation. 5. The IDT (Interdisciplinary Team) was to review new admissions during morning meeting to ensure the admission was complete, orders were verified and medications were available to be administered. IDT was to review this starting 09/17/2021 daily for two (2) weeks. 6. The ED and/or DON were to review audit results weekly for four (4) weeks. 7. The DON and/or the ED were to report the audit results weekly to the QAPI Committee. The State Survey Agency (SSA) validated the facility's removal of immediacy plan by: 1. Record review revealed Resident #2 was discharged on [DATE] and was no longer in the facility. 2. Review of the facility's documentation revealed an ADHOC meeting was held on 09/13/2021 with the ED, DON, and Physician in attendance. Interview with the ED, DON, and Physician on 09/17/2021 revealed during the ADHOC meeting, the SSA findings were discussed and steps were identified to remove the immediacy and to ensure the identified concerns would not reoccur. 3. Review of the facility's documentation revealed an audit was completed by the DON of the past thirty (30) days of admissions, starting on 09/08/2021. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed she completed the audit and any identified concerns were corrected immediately upon discovery. 4. Review of the facility's documentation revealed education was provided to all licensed staff on or before 09/16/2021, with a posttest administered. Continued review revealed certified letters were mailed to employees who had not yet received the education. Interview with DON, ADON, and Unit Manager (UM), on 09/17/2021, revealed they had completed education with licensed staff. Per interview, the staff the facility was unable to contact were sent certified letters informing them they were to be reeducated before returning to work. The DON, ADON and UM revealed a posttest had been given and results reviewed on site with discussion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #2 on 09/17/2021 at 1:36 PM, revealed she received education on the new admission process including assessment and medication and was given a posttest. Interview with LPN #5, on 09/17/2021 at 1:27 PM, revealed she was reeducated regarding the admission process and was given a post test. Interview with LPN #3, on 09/17/2021 at 1:13 PM, revealed she was reeducated on the admission process and was given a posttest. 5. Review of the facility's documentation revealed during morning meeting the IDT reviewed new admissions from the previous day to ensure the admission process was completed, orders verified and medications were available, which started 09/17/2021. Interview with the IDT members, on 09/17/2021 at 10:15 AM and 10:35 AM, revealed they reviewed the new admissions to ensure the admission process was completed and medications were available and orders verified. 6. Review of the facility's documentation regarding audits revealed the ED had been reviewing the audit results daily. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she was reviewing audits more often than what was stated in the AOC, she had been reviewing them daily. 7. Review of the facility's documentation revealed the ED/DON were to report the audit results to QAPI weekly. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she had been reviewing the audits and discussing trends and improvements with the QAPI team. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed the QAPI had the first meeting today and they reviewed and discussed the last two (2) days of QAPI findings. Interview with the QAPI Committee, on 09/17/2021 at 10:15 AM and 10:35 AM, revealed they reviewed the audit results and discussed improvements.

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety 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** 42857 Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a secure and organized transfer was provided for one (1) of nine (9) sampled residents (Resident #1). The facility failed to provide adequate preparation and direction for Resident #1 in a form and manner he/she could comprehend prior to discharging the resident. Interview and record review revealed prior to Resident #1's admission to the facility, the hospital informed facility staff on 06/30/2021, that the resident had an appointed State Guardian. The facility's care plan for Resident #1 noted interventions which included contacting the resident's Guardian for discharge planning. However, on 07/19/2021, facility staff approached Resident #1 and had the resident sign Against Medical Advice (AMA) paperwork, and subsequently discharged him/her to a homeless shelter via a cab, paid for by the facility. Additionally, the facility failed to ensure the resident was provided discharge education and/or received education related to his/her medications. Additionally, the facility failed to provide Resident #1, who was an insulin dependent Diabetic, with any medications at the time of discharge. Resident #1 presented to a local hospital's Emergency Department (ED) on 07/20/2021, with a blood glucose level of 388 mg/dL (milligrams per deciliter [normal 70-130]) and an elevated potassium level of 6.1 mmol/L (millimoles per liter [normal 3.6 - 5.2]). Resident #1 was admitted to the hospital for treatment of those conditions. The facility's failure to ensure a safe and orderly transfer has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/03/2021 and was determined to exist on 07/19/2021, at 42 CFR 483.15 Admission, Transfer, and Discharge (F624), 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), and 42 CFR 483.40 Behavioral Health Services (F745) at a Scope and Severity of J. The facility was notified of the Immediate Jeopardy on 09/03/2021. The facility submitted an acceptable Allegation of Compliance (AOC) on 09/17/2021 and alleged past noncompliance and removal of immediacy on 07/22/2021. The State Survey Agency validated past noncompliance, as alleged, with removal of immediacy on 07/22/2021. The findings include: Review of the facility's policy entitled, Discharge AMA - Against Medical Advice Guidelines, dated 04/15/2020, revealed the facility encouraged residents to discuss their motivation for wanting to leave and attempt to resolve the resident's concerns. Continued review revealed staff were to inform a resident wanting to discharge AMA, of the possible medical complications of the discharge. Per review, the facility staff were to have the resident acknowledge his/her understanding of the risk of discharging without the Physician's approval. Per policy review, the facility was to notify the resident's Attending Physician, and responsible party. Further review revealed staff were to also notify the facility's Executive Director (ED), and Director of Nursing (DON). In addition, the facility was to not give medications to a resident wishing to leave AMA without consulting his/her Physician. (continued on next page)

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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 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy entitled, Discharge Planning Process, dated 01/10/2018, revealed it was purposeful for the facility to have a discharge planning process which ensured each resident's discharge goals and needs, including care giver support addressed prior to discharge. Continued review revealed a discharge plan of care was to be developed for each resident and it was to be included in the resident's Comprehensive Care Plan (CCP). Per policy, the discharge care plan was to be developed by the facility's Interdisciplinary Team (IDT) with the residents' and/or his/her representative's involvement. Further review revealed the discharge care plan was to address the resident's goals and treatment, identify needs which had to be addressed before the resident could be discharged such as; resident education, rehabilitation, and caregiver support. Per review, the discharge care plan was to identify any post-discharge needs the resident might have, and be reevaluated and updated when the resident's needs or goals changed. The discharge care plan was also to have any referrals made to local agencies documented. Additionally, if the resident wished to be discharged to a setting which did not appear to meet his/her needs, or appeared unsafe the facility was to discuss that information with the resident. Further review revealed the facility was to ensure the risks of being discharged to a place which did not meet the resident's needs was discussed and documented. In addition, the facility was to document discussion with the resident of other suitable options for him/her to discharge to; document any refusals by the resident; and, determine if a referral to Adult Protective Services (APS) was necessary. Record review revealed the facility admitted Resident #1 on 06/30/2021, with diagnoses which included Cognitive Communication Deficit, Dysphagia, Heart Disease, Type 2 Diabetes Mellitus, Muscle Weakness, Hypertension, Anxiety, Depression and Unsteadiness. Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/07/2021, revealed the facility assessed Resident #1 to have moderate cognitive impairment per the Brief Interview for Mental Status (BIMS) examination. Continued review revealed the facility assessed Resident #1 as frequently incontinent of bowel and bladder, to require extensive assistance of one (1) person for: toileting; personal hygiene; and bed mobility. Per review, the facility assessed the resident as totally dependent on staff for bathing, and required the use of a wheelchair for mobility in the facility. Further review revealed the facility assessed Resident #1 to require insulin injections for his/her diagnosis of Type 2 Diabetes Mellitus. Review further revealed the facility assessed Resident #1 as receiving numerous medications to treat his/her other medical diagnoses. Review of Resident #1's Comprehensive Care Plan (CCP) revealed a discharge care plan was initiated on 07/01/2021, for the resident with interventions which included contacting his/her Guardian for the discharge planning. Per review, additional interventions included identifying any equipment needed while the resident resided in the facility, and determining if the resident would need any follow up appointments. Further review of the CCP revealed Resident #1 was care planned as at risk for falls related to weakness, and to require assistance with his/her Activities of Daily Living (ADL's) related to weakness and decreased mobility. In addition, review of the CCP revealed Resident #1 had been care planned as a potential nutritional risk and he/she wandered. Interview with Resident #1's State Appointed Guardian, on 08/23/2021 at 1:04 PM, revealed the resident became a ward of the State under State Guardianship on 07/01/2021. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the hospital's Licensed Clinical Social Worker (LCSW), on 08/24/2021 at 9:12 AM, revealed she had communicated with the facility's Liaison #2 via text message in regards to Resident #1 being in transition from having a family member as Guardian to having a State Appointed Guardian. The LCSW stated Resident #1 still had a Guardian. Review of the documentation provided by the hospital's LCSW, on 09/03/2021, revealed the LCSW had communicated with the facility's Liaison #2 on 06/25/2021, regarding Resident #1's Guardian information. Further review revealed the LCSW had communicated with Liaison #2 again on 06/30/2021, confirming Resident #1's Guardianship status, with a notation of Liaison #2 replying with a confirmation of receiving the information. Interview with the facility's Liaison #2, on 08/25/2021 at 9:04 AM, revealed she was in frequent communication with the hospital LCSW regarding Resident #1 prior to the resident's admission. Continued interview revealed she had received the hospital documentation regarding Resident #1. However, she never received any Guardianship paperwork from the hospital's LCSW. Further interview revealed she was unable to recall the hospital's LCSW sharing any information regarding Resident #1's Guardianship status with her. Review of Resident #1's Physician's Order, dated 06/30/2021, revealed the resident had been prescribed numerous medications for his/her health related conditions. Continued review of the Order revealed Resident #1's prescribed medications included: Clonidine (antihypertensive), Depakote (for behaviors), Donepezil (for Dementia), Eliquis (anticoagulation), Insulin Lispro (Diabetes injection medication), Imdur (antihypertensive), Insulin Glargine (Diabetes injection medication), Namenda (for Dementia), Metoprolol (antihypertensive), Ranolazine (for chest pain), Spironolactone (diuretic), and Effexor (for Depression). Review of Resident #1's Progress Note, dated 07/12/2021 at 3:17 PM, revealed a seventy-two (72) hour meeting had been held which included Resident #1, Therapy staff and the Social Services Director (SSD) to discuss the resident's discharge plan while he/she was residing in the facility. Continued review revealed documentation that noted Resident #1 needed to stay in the facility for at least two (2) more weeks to continue to improve and gain more independence. Per the Progress Note, Resident #1 required cues from staff regarding safety awareness before transfers to avoid falling. Further review revealed Resident #1 was unable to transfer out of his/her wheelchair to stand during the meeting. Record review revealed Resident #1 asked the staff present if he/she could stay and continue to work with Therapy to improve in transferring, gain more Activities of Daily Living (ADL) independence and improve his/her continence. Additional review of the Progress Notes revealed a Note dated 07/17/2021, documented by Licensed Practical Nurse (LPN) #5, who noted that Resident #1 had been found in another resident's room rummaging through that resident's belongings. Continued review revealed when staff redirected Resident #1 from the other resident's room, he/she tried to enter the other resident's room again shortly after being redirected. Further review of the Note revealed the DON was notified and Resident #1 was placed on 1:1 supervision. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #5, on 08/25/2021 at 1:43 PM, revealed the Aide had notified her of Resident #1 being in another resident's room, and had tried to reenter the room after being redirected by staff. Interview revealed the incident happened on a Saturday, and staff telephoned (phoned) the DON, who was the Manager on duty that day regarding the incident. LPN #5 stated the DON had instructed staff to place Resident #1 on 1:1 supervision, and that on Monday (this incident happened on a Saturday) the facility would go from there. Review of the Discharge Note for Resident #1, dated 07/19/2021 at 11:43 AM, completed by LPN #3, revealed no documented evidence of discharge education, or education related to the resident's medications having been provided for the resident prior to discharge. Further review of the Discharge Note revealed no documented evidence of any Durable Medical Equipment (DME) having been sent with Resident #1 when the facility discharged him/her. Additionally, there was no documented evidence the facility supplied Resident #1 with needed supplies such as incontinence products, food items or any monetary way to purchase those items. Review of the hospital records (after discharge from the facility), dated 07/20/2021, revealed Resident #1 presented to the hospital ED with a blood glucose of 388 and a potassium of 6.1. Continued review revealed Resident #1 was hospitalized and diagnosed with Hyperglycemia (high blood sugar), Hyperkalemia (high potassium), and leg pain, secondary to lack of having medications to take for his/her health conditions. Interview with Resident #1, on 09/02/2021 at 8:50 AM, revealed when he/she left the faciity on [DATE], the resident was not provided any education regarding his/her medications. Further interview revealed the facility had not provided the resident with any money to purchase care supplies he/she might have needed. Interview with the Social Services Director (SSD), on 08/24/2021 at 9:18 AM, revealed she had been present at the facility's morning meeting on 07/19/2021, when the DON stated Resident #1 was leaving the facility AMA that day. The SSD stated she voiced her concerns to the DON that she believed Resident #1 was not safe to discharge due to the resident requiring a personal wheelchair which he/she did not have. Continued interview revealed the DON told her to give Resident #1 a facility wheelchair and let the resident go on and leave. The SSD stated she notified LPN #3, after her discussion with the DON, to review the AMA paperwork with Resident #1 and have him/her ready for discharge. She stated she had worked in the facility for over twenty (20) years and calling the Physician had always been a standard for any resident wanting to leave AMA. According to the SSD, she approached LPN #3 and asked if Resident #1 was ready for discharge and the nurse replied yes, so she assumed the Physician had been notified. Further interview revealed she witnessed the AMA paperwork and along with LPN #3, set up transportation via a cab and discharged Resident #1 to a homeless shelter. Additionally, she stated after Resident #1 left the facility, she notified Adult Protective Services (APS) as she felt the resident's discharge was unsafe. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON), on 08/25/2021 at 3:23 PM, revealed the facility's discharge planning process was initiated on a resident's admission and usually the SSD lead the discharge process to ensure the resident had all he/she needed. The ADON stated the facility had a conversation regarding Resident #1 and potentially finding placement for him/her at another more suitable facility related to his/her wandering. Continued interview revealed during the facility's morning meeting on 07/09/2021, the DON stated Resident #1 had to go because he/she had been found over the weekend in another resident's room stealing that resident's things. She stated she believed the Physician had not been notified prior to Resident #1's AMA discharge, and there was no documentation in the resident's record noting the Physician had been notified. Interview revealed she had performed a review of Resident #1's medical records and noticed the morning of Resident #1's discharge day, his/her blood sugar was greater than 400, with no documentation noting the Physician had been notified of that information. The ADON further revealed with a blood sugar that high, Resident #1 could have become confused, and she thought the homeless shelter Resident #1 was discharged did not provide medical care. Interview with LPN #2, on 08/25/2021 at 11:06 AM, revealed it was important for residents to experience a safe discharge. Per interview, it was also important for staff to ensure residents being discharged were properly educated regarding their medications. LPN #2 stated for a resident being discharged staff should check his/her ambulation status, and identify any potential safety concerns. Further interview revealed while educating the resident prior to discharge was important, it was also crucial for staff to ensure the resident could comprehend and understand the education being provided. Interview with LPN #3, on 09/03/2021 at 10:00 AM, revealed she had gone over the AMA paper work with Resident #1 on 07/19/2021. She stated she had been instructed that everything else had been completed, and she just needed to review the AMA paperwork with Resident #1. Continued interview revealed it was important to notify the Physician regarding a resident wanting to leave AMA, as the Physician might give additional orders and could give the okay for allowing the resident to leave with his/her medications. Additionally, she revealed Resident #1 had not left the facility with any medications on the day of discharge, and that was why she had explained to the resident the importance of following up with a Primary Care Physician after discharge. Interview with LPN #4, on 08/23/2021 at 2:45 PM, revealed when a resident wished to leave AMA, the Physician was to be notified because he may give proper discharge orders and allow the resident to leave with his/her medications. She revealed it was important for residents to have a safe discharge which ensured the residents remained out of harm's way once they left the facility. Additionally, she stated she believed there had been a better place for Resident #1 to have been discharged to besides the homeless shelter. Interview with LPN #5, on 08/25/2021 at 1:43 PM, revealed she was Resident #1's assigned nurse on 07/19/2021. She stated during her morning medication pass she did not recall Resident #1 coming to her and expressing wishes to leave the facility AMA. Continued interview revealed the LPN was pulled to another unit around 9:00 AM and when she returned to the unit where Resident #1 resided at 4:00 PM, she was informed Resident #1 had left the facility AMA that morning. She further revealed Resident #1 leaving AMA was not safe due to his/her history of blood clots, and the resident was not capable of transferring himself/herself safely. LPN #5 stated Resident #5 required assistance with transfers. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's previous DON, on 08/25/2021 at 1:27 PM, revealed during Resident #1's stay at the facility, he/she had mentioned leaving prior to being discharged AMA on 07/19/2021. Per interview, staff were able to deescalate the resident previously when he/she spoke of leaving the facility AMA. The DON stated she explained to Resident #1 why it was important that he/she stayed in the facility. Continued interview revealed in the facility's morning meeting on Monday, 07/19/2021, she had notified the SSD of Resident #1 expressing his/her wishes to leave AMA that day. The previous DON stated she believed the SSD was in charge of discharge planning and the discharge care plan. Further interview revealed she was notified by the ADON of LPN #3 notifying the Physician prior to Resident #1 leaving AMA. Additionally, interview revealed Resident #1 was adamant that he/she was admitted to the facility with his/her own wheelchair, so the facility allowed the resident to take the wheelchair he/she had used while residing in the facility. Further interview revealed the facility also gave Resident #1 a list of his/her currently prescribed medications; however no medications were given to the resident. The DON further revealed after Resident #1 was discharged from the facility, the SSD notified APS due to her concerns that the resident's discharge was not safe. Interview with the previous Executive Director (ED), on 08/26/2021 at 4:30 PM, revealed she was not in attendance at the facility's morning meeting on 07/19/2021. She stated no one made her aware Resident #1 was discharged AMA until after the resident had already left the facility. Continued interview revealed per the facility's policy, she should have been notified prior to Resident #1 being discharged AMA in order for her to attempt to resolve any concerns the resident had. Per interview, if she had been able to resolve Resident #1's concerns, he/she might have stayed at the facility. The former ED stated residents' discharge plans started on admission and the SSD and clinical team lead the discharge planning. Further interview revealed it was important that the facility ensured a safe discharge for residents in order for them to be safe, and prevent any re-hospitalization s. In addition, she stated she expected facility staff to make proper notifications as required, and follow the facility's policy regarding AMA discharges. She further revealed the Physician was to be notified of a resident discharging AMA. Interview with the Medical Director, on 09/03/2021 at 1:45 PM, revealed he was notified when Resident #1 requested to leave AMA; however, he had not provided facility staff with any further orders. He stated Resident #1 had been alert and oriented, and the facility had not been aware the resident had a Guardian. Interview with the SSD, on 09/03/2021 at 2:56 PM, revealed discharge planning was initiated on a resident's admission to the facility. Per interview, the goal was for the best possible outcome for a new resident. She stated it was important after being discharged for the resident to maintain their goals in order for them to remain safe. Additionally, she revealed it was never the facility's goal to discharge Resident #1 to an unsafe place because something adverse could potentially happen to the resident. Interview with the facility's current Acting DON, on 09/03/2021 at 2:01 PM, revealed the facility's discharge process began on a resident's admission, and was to be reviewed regularly with the IDT. Additional interview revealed the facility's goal was resident safety when discharging from the facility, and for the resident being discharged to have everything they needed to be successful after discharge. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's current ED, on 09/03/2021 at 3:23 PM, revealed the IDT and SSD were supposed to be working closely together to ensure safe discharges for all residents. She revealed residents wanting to leave AMA were to be educated on the risks and the potential of losing out on services after they left the facility. Per interview, it was the facility's responsibility to ensure a resident was safely discharged . Further interview revealed if a resident wished to leave the facility AMA, the facility could not ensure that certain needs of the resident were obtained. The facility alleged it implemented the following actions to remove immediacy: 1. Regional [NAME] President of Operations (RVPO) and [NAME] President of Clinical Services (VPCS) reeducated the Interdisciplinary Team (IDT) which included the Executive Director (ED), Director of Nursing (DON), Social Services Director (SSD) Dietary Manager (DM), Maintenance Director, Therapy Director, Activity Director Assistant Director of Nursing (ADON), Human Resources Director (HR), Scheduler, Minimum Data Set (MDS) Coordinator, Assistant Housekeeping Director, and Admission Director on 07/20/2021. The education included Against Medical Advice (AMA) Policy, AMA form, and the policy on Change in a Resident's Condition/Status (CIC) which included discharge without proper medical authority and care plan revisions to ensure a safe discharge with a posttest administered. 2. On 07/21/2021, the RVPO and VPCS completed an audit on all current residents to ensure guardian status paperwork was in the medical record. 3. On 07/21/2021, the RVPO and VPCS completed an audit of all discharges from 06/01/2021 through 07/21/2021 to ensure proper discharge notification based on guardianship status. 4. The ED, DON, and SSD are no longer employed at the facility effective 07/21/2021. 5. Newly hired management members such as the ED, DON and SSD received education regarding care plan and discharge processes that included CIC, discharge without proper medical authority and care plan revision, with a posttest. 6. When hired, the new SSD will receive education related to ensuring when residents were discharge they were provided with sufficient medical related social services. 7. Beginning 07/21/2021, any new admissions will be audited by the IDT for guardianship status and discharge care planning five (5) days week for (6) months. 8. The ED and/or DON will review results of the audits daily. 9. The ED, DON, and/or SSD will submit results of the audit findings weekly x 6 months to the Quality Assurance Performance Improvement (QAPI) Committee which is the IDT until the issue is resolved. The State Survey Agency (SSA) validated the removal plan by: 1. Record review revealed reeducation was provided to the IDT team with a posttest provided with a completion score of 100% to all IDT members. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the IDT, on 09/17/2021 at 10:09 AM, 10:15 AM and 10:35 AM, revealed they received educations regarding the AMA policy and the form along with discharge procedures for someone wanting to leave AMA along with the care plan updates to ensure a safe discharge. 2. Record review revealed on 07/21/2021, Resident #1's care plan was updated to reflect guardianship status. Interview with the MDS Coordinator on 09/147/2021 at 12:33 PM, revealed she updated Resident #1's care plan to reflect his/her guardianship status. 3. Record review revealed on 07/21/2021 the RVPO and VPCS completed an audit of all discharges from 06/01/2021 through 07/21/2021 to ensure proper notification based on guardianship status. Interview with the Regional [NAME] President of Operations (RVPO), on 09/17/2021 at 9:20 AM, revealed she completed the audit to ensure no one was missed and to make sure they had any current in house guardianships that they were reflected on the medical record. Interview with the [NAME] President of Clinical Services (VPCS), on 09/17/2021 at 2:33 PM, revealed she assisted with audits and reviewed any guardianship discharges to ensure proper notifications were made. 4. Interview with the previous ED, DON and SSD revealed they are no longer employed at the facility. 5. Record review revealed newly hired management members, the ED DON and SSD received educations on care plans and the discharge process. Interview with the ED and DON, on 09/17/2021 at 2:06 PM, revealed she completed education on day of hire and completed a posttest that was reviewed and any question were discussed. 6. Interview with the SSD, on 09/17/2021 at 12:35 PM, revealed she completed education upon hire regarding care plan revisions and discharge processes and completed a posttest with discussion afterward. 7. Record review revealed audits were completed starting 07/21/2021 on new admissions for guardianship status and discharge care planning. Interview with the IDT, on 09/17/2021 at 10:09 AM, 10:15 AM and 10:35 AM, revealed new admissions were being reviewed in the clinical meetings to review for guardianship status and discharge care plans. 8. Record review of the audit revealed the ED has been reviewing the audit results daily. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she reviewed audits daily. 9. Record review revealed the ED/DON reported the audit results to QAPI weekly. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42857 Based on interview, record review and facility policy review, it was determined the facility failed to implement the Comprehensive Person-centered Care Plan for one (1) of nine (9) sampled residents (Resident #1). The facility admitted Resident #1 on 06/30/2021. Resident #1 had a State Appointed Guardian. Resident #1's Discharge Care Plan which was initiated on 07/01/2021, had interventions that included for staff to contact guardian for discharge planning. The facility approached Resident #1 and had the resident sign Against Medical Advice (AMA) paperwork. The facility discharged Resident #1 on 07/19/2021 to a local homeless shelter. The facility failed to implement Resident #1's care plan intervention to contact his/her Guardian for discharge planning. The facility's failure to implement a comprehensive person-centered care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/03/2021 and was determined to exist on 07/19/2021, at 42 CFR 483.15 Admission, Transfer, and Discharge (F624), 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), and 42 CFR 483. 40 Behavioral Health Services (F745) at a Scope and Severity of J. The facility was notified of the Immediate Jeopardy on 09/03/2021. The facility submitted an acceptable Allegation of Compliance (AOC) on 09/17/2021 and alleged past noncompliance and removal of immediacy on 07/22/2021. The State Survey Agency validated past noncompliance, as alleged, with removal of immediacy on 07/22/2021. The findings include: Review of the facility's policy titled, Comprehensive Care Plan, dated 01/13/2018, revealed the purpose of the policy was to ensure the provision of services to enable residents to live with dignity. Per review, the policy's purpose also included supporting the resident's goals, choices, and preferences including goals related to their daily routines. The Comprehensive Care Plan described the services furnished were to help resident's attain, or maintain his/her highest practicable physical, mental, and psychosocial well-being. Review of Resident #1's medical record revealed the facility admitted the resident on 06/30/2021, with diagnoses which included Heart Disease, Muscle Weakness, Type 2 Diabetes Mellitus, Dysphagia, Unsteadiness, Cognitive Communication Deficit, Weakness, Hypertension, Depression, and Anxiety. Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/07/2021, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated the resident was moderately cognitively impaired. Continued review revealed the facility assessed Resident #1, with the expectation of being discharged to the community when appropriate, with no referrals needed. (continued on next page)

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	185176	A. Building B. Wing	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Oaks Care and Rehab Center, LLC	446 Mt. Holly Avenue Louisville, KY 40206

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The State Survey Agency (SSA) Surveyor requested the facility provide a Comprehensive Care Plan (CCP) with revisions for Resident #1 on 07/27/2021. Review of the CCP provided revealed the facility had initiated a Discharge Care Plan on 07/01/2021 for Resident #1, with the focus of Discharge Plan is Homeless Program for Housing. Further review revealed the interventions initiated on 07/01/2021 included: Contacting the Guardian for discharge planning; identify equipment needed while residing in the facility; and, identifying whether the resident needed any follow up appointments. Review of the Progress Notes, dated 07/19/2021, revealed Resident #1 left AMA from the facility at 11:00 AM. Continued review revealed no documented evidence the State Appointed Guardian for Resident #1 was notified as per the care plan interventions. Per review, there was no documented evidence Resident #1 was educated prior to his/her discharge on 07/19/2021. Additionally, there was no documented evidence the facility supplied Resident #1 with needed supplies such as incontinence products, food items or any monetary way to purchase those items. Interview with Licensed Practical Nurse (LPN) #4, on 08/23/2021 at 2:45 PM, revealed the care plan was a plan which described each individual resident's needs. She stated it was important to follow residents' care plans and interventions, to ensure the residents were receiving the appropriate care. Further interview revealed if residents' care plan interventions were not followed, staff could not be sure they were giving the residents the right care. Interview with the facility's previous Director of Nursing (DON), on 08/25/2021 at 1:27 PM, revealed a resident's care plan was a person centered plan on how the facility could meet the resident's needs and help them achieve their goals. She stated it was important staff implemented residents' care plan interventions to ensure residents received the proper care they required. Further interview revealed if staff did not follow and implement residents' care plan interventions, the residents would not receive the necessary care and services they required. She further stated she was not aware Resident #1's Discharge Care Plan stated to contact his/her Guardian prior to discharge. Interview with the previous Executive Director (ED), on 08/26/2021 at 4:30 PM, revealed she expected her staff to follow all residents' care plans and implement the interventions to ensure residents received the necessary goods and services they required. The facility alleged it implemented the following actions to remove immediacy: 1. Regional [NAME] President of Operations (RVPO) and [NAME] President of Clinical Services (VPCS) reeducated the Interdisciplinary Team (IDT) which included the Executive Director (ED), Director of Nursing (DON), Social Services Director (SSD) Dietary Manager (DM), Maintenance Director, Therapy Director, Activity Director Assistant Director of Nursing (ADON), Human Resources Director (HR), Scheduler, Minimum Data Set (MDS) Coordinator, Assistant Housekeeping Director, and Admission Director on 07/20/2021. The education included Against Medical Advice (AMA) Policy, AMA form, and the policy on Change in a Resident's Condition/Status (CIC) which included discharge without proper medical authority and care plan revisions to ensure a safe discharge with a posttest administered. 2. On 07/21/2021, the RVPO and VPCS completed an audit on all current residents to ensure guardian status paperwork was in the medical record. 3. On 07/21/2021, the RVPO and VPCS completed an audit of all discharges from 06/01/2021 through 07/21/2021 to ensure proper discharge notification based on guardianship status. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The ED, DON, and SSD were no longer employed at the facility effective 07/21/2021. 5. Newly hired management members such as the ED, DON, and SSD received education regarding care plan and the discharge process to include CIC, discharge without proper medical authority and care plan revision, with a posttest. 6. Beginning 07/21/2021, any new admissions were to be audited by the IDT for guardianship status and discharge care planning five (5) days week for six (6) months. 7. The ED and/or DON were to review results of the audits daily. 8. The ED, DON, and/or SSD were to submit results of the audit findings weekly times (x) six (6) months to the Quality Assurance Performance Improvement (QAPI) Committee which is the IDT until the issue is resolved. The State Survey Agency (SSA) validated the removal plan by: 1. Review of facility documentation revealed reeducation was provided to the IDT team with a posttest provided and a completion score of 100% to all IDT members. Interview with the IDT, on 09/17/2021 10:09 AM, 10:15 AM and 10:35 AM, revealed they received education regarding the AMA policy and the form along with discharge procedures for someone wanting to leave AMA along with the care plan updates to ensure a safe discharge. 2. Record review revealed on 07/21/2021, Resident #1's care plan was updated to reflect guardianship status. Interview with the MDS Coordinator on 09/17/2021 at 12:33 PM, revealed she updated Resident #1's care plan to reflect his/her guardianship status. 3. Review of the facility's documentation revealed on 07/21/2021, the Regional [NAME] President of Operations (RVPO), and [NAME] President of Clinical Services (VPCS) completed an audit of all discharges from 06/01/2021 through 07/21/2021 to ensure proper notification based on guardianship status. Interview with the RVPO, on 09/17/2021 at 9:20 AM, revealed she completed the audit to ensure no one was missed and to make sure they had any current in house guardianships that they were reflected on the medical record. Interview with the VPCS, on 09/17/2021 at 2:33 PM, revealed she assisted with audits and reviewed any guardianship discharges to ensure proper notifications were made. 4. Interview with the previous ED, DON and SSD revealed they were no longer employed at the facility. 5. Review of facility documentation revealed newly hired management members, the ED, DON and SSD received educations on care plans and the discharge process. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the ED and DON, on 09/17/2021 at 2:06 PM, revealed she completed education on day of hire and completed a posttest that was reviewed and any questions were discussed. 6. Review of facility documentation revealed audits were completed starting 07/21/2021 on new admissions for guardianship status and discharge care planning. Interview with the IDT, on 09/17/2021 at 10:09 AM, 10:15 AM and 10:35 AM, revealed new admissions were being reviewed in clinical meeting to review for guardianship status and discharge care plans. 7. Review of facility documentation of the audits revealed the ED had been reviewing the audit results daily. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she was reviewing the audits daily. 8. Review of facility documentation revealed the ED/DON were to report the audit results to QAPI weekly. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she had been reviewing the audits and discussing trends and improvements with the QAPI team. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed the QAPI meeting had been discussing trends and improvements based on the audit findings. Interview with the QAPI Committee, on 09/17/2021 at 10:15 AM and 10:35 AM, revealed they reviewed the audit results and discussed improvements.

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42857 Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the provision of pain management for one (1) of nine (9) sampled residents (Resident #2). The facility admitted Resident #2 on 04/17/2021, with Physician's Orders which included a narcotic pain medication every four (4) hours as needed (PRN) for pain. The facility failed to complete any pain assessments while Resident #2 was admitted and failed to administer the PRN pain medication after the resident requested it. Prior to admission to the facility, Resident #2 had several surgeries on his/her buttocks while in the hospital, which the resident stated caused him/her constant pain. Approximately twelve (12) hours after being admitted to the facility, Resident #2 requested to be sent back to the acute care hospital related to unrelieved pain. Review of the hospital record revealed the hospital administered Morphine (an opioid used to treat moderate to severe pain). The facility's failure to provide pain management has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/13/2021 and was determined to exist on 04/17/2021. Immediate Jeopardy was determined to exist at CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), CFR 483.25 Quality of Care (F697) at a Scope and Severity of J. The facility was notified of the Immediate Jeopardy on 09/13/2021. The facility submitted an acceptable Allegation of Compliance (AOC) on 09/17/2021 and alleged removal of immediacy on 09/17/2021. The State Survey Agency validated removal on 09/17/2021, as alleged. Furthermore, on 09/17/2021, the State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 09/17/2021, prior to exit on 09/17/2021, with remaining non-compliance at 42 CFR 483.25 Quality of Care, Pain Management (F697) at a S/S of D, while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Pain Assessment and Management, revised 03/2020, revealed the policy was to assist staff with identifying a resident's pain. Per review, the policy was also to assist in developing interventions which were consistent with the resident's goals and needs and address the underlying cause of his/her pain. Continued review revealed the policy defined pain management as the process of alleviating a resident's pain based on his/her clinical condition and established treatment goals. The policy stated the facility's pain management program was based on its commitment to the treatment of a resident's pain. Continued review of the policy revealed staff were to complete comprehensive pain assessments upon a resident's admission to the facility and a resident's acute pain was to be assessed every thirty (30) to sixty (60) minutes after the onset using a consistent approach and standardized pain assessment instrument appropriate to the resident's cognitive level. Further review revealed staff were to document the resident's reported pain level after assessing him/her. The policy further revealed staff were to reassess the resident's pain as indicated until the resident achieved pain relief, and were to ensure all assessment/reassessment information was recorded in his/her medical record. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Preparation for Medication Administration, revised 12/14/2015, revealed when staff administered PRN medications they were to document the date and time, dose and route of administration. Further review revealed staff were also to document the resident's complaints or symptoms at the time of administration, and note whether the pain medication was effective. In addition, staff were to ensure they documented their signature/initials when recording the pain medication administration. Review of Resident #2's medical record revealed the facility admitted him/her on 04/17/2021 via ambulance at approximately 12:15 PM. Per review Resident #2 was admitted with diagnoses which included Cellulitis of the Buttock, Cutaneous Abscess of Buttock, Type 2 Diabetes Mellitus, Sepsis and Hypertension. Continued review revealed staff entered Resident #2's information into the facility's Electronic Health Record (EHR) system at 2:05 PM on the day of admission. Further review revealed Resident #2 resided in the facility for approximately twelve (12) hours. Review of the hospital record revealed the hospital admitted Resident #2 to the emergency department on 04/18/2021 and administered morphine and began intravenous (IV) administration of an antibiotic. Review of the hospital Discharge Summary, dated 04/16/2021, revealed Resident #2 was admitted to the hospital on 04/03/2021 with sharp/aching constant non-radiating pain which worsened with movement. Per review, Resident #2 had rated his/her pain as a ten (10) out of a possible ten (10) on the pain scale, which was the worst pain level. Continued review of the Discharge Summary revealed Resident #2's discharge medication list included Norco (a narcotic pain medication) 10-235 milligram (mg), one (1) tablet by mouth (PO) every four (4) hours as needed (PRN) for pain. Review of Resident #2's Physician's Orders, dated 04/17/2021, revealed the resident's pain medication, Norco 10-325, had been entered into his/her EHR on 04/17/2021 at 5:02 PM. Continued review revealed an order, entered into Resident #2's EHR on 04/17/2021 at 5:34 PM, for staff to Monitor Pain and Document the resident's pain level every shift. Review of Resident #2's Medication Administration Record (MAR), dated 04/2021, revealed no documented evidence of the resident's PRN Norco pain medication having been administered while he/she resided in the facility for the twelve (12) hours. Continued review of the MAR revealed no documented evidence of staff noting they had monitored and documented Resident #2's pain level every shift as per the Physician's Order while he/she was at the facility. Review of Assessments noted in Resident #2's Medical Record revealed no documented evidence a pain assessment was completed for the resident after admittance to the facility on [DATE]. In addition, review revealed no documented evidence of pain assessments noted prior to Resident #2 being sent back to the hospital on 04/18/2021, due to his/her unrelieved pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #2, on 09/02/2021 at 11:54 AM, revealed staff had not even recognized he/she was living in the facility until four (4) or five (5) hours after being admitted , when he/she had to walk down the hallway to inquire about his/her meals and medications. Continued interview revealed Resident #2 had several surgeries performed on his/her buttock due to an abscess. Resident #2 stated staff had said his/her pain medications would not be delivered to the facility until 2:00 AM on 04/18/2021, greater than twelve (12) hours after his/her admission. Further interview revealed Resident #2's pain was constant and it hurt to use the restroom, lay down or do pretty much anything due to the wound on his/her buttock. In addition, Resident #2 stated he/she had not received any pain medication after leaving the hospital on 04/17/2021, and he/she was in pain. Review of the facility's Emergency Drug System Inventory documentation located in the Medication Room revealed three (3) Norco 10-325 mg tablets were available on 04/17/2021 for administration to Resident #2. Further review revealed attempts were made to retrieve the pain medication from the Emergency Drug System; however, they were unsuccessful. Continued review revealed Certified Medical Technician (CMT) #1 accessed the Emergency Drug System and attempted to pull the Norco 10-325 mg tablet from the system but skipped the medication which was not pulled or administered to Resident #2. Interview with the Data Entry Technician from the facility's Provider Pharmacy, on 09/07/2021 at 10:50 AM, revealed when a new resident's admission medication orders were entered into the facility's EHR system, the Pharmacy was notified of the admission and their medications. She stated orders for medications not available in the facility's Emergency Drug Kit, which were due before the Pharmacy's normal delivery time, were sent STAT (immediately) to a local back-up twenty-four (24) hour Pharmacy to be filled and delivered. Per interview, that process ensured facility staff had the medications required and prevented a delay in administration. Continued interview revealed the Pharmacy received Resident #2's first medication orders on 04/17/2021 at 6:24 PM. The Data Technician revealed Norco 10-325 was available in the facility's Emergency Drug System for administration. According to the Data Technician, the Pharmacy had documentation noting the drawer in which the Norco medication was stored in the facility's Emergency Drug System had been pulled open; however, an actual tablet was not removed from the system drawer and administered per the documentation. Further interview revealed the pain medication was skipped for some reason, but there was nothing which showed the Pharmacy why the medication was skipped. Interview with the facility's Pharmacy's Office Manager, on 09/08/2021 at 9:35 AM, revealed when the Emergency Drug System was fully stocked, it contained six (6) of the Norco 10-325 mg tablets. He stated he was unable to go back to 04/17/2021, and review how many tablets of the pain medication were actually available in the facility's Emergency Drug System. He revealed if the system had not had any of the Norco available to pull it would notify the staff person making the attempt and denied them access to the drawer the medication was stored. Further interview revealed if that occurred the medication order would then be sent STAT to the local back-up Pharmacy who would supply the medication. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #2, on 09/07/2021 at 10:03 AM, revealed she worked the 7:00 PM - 7:00 AM (night) shift at the facility, and had started working there on 04/17/2021, the day Resident #2 was admitted . Per interview, LPN #1 had not informed her of Resident #2's arrival, during the change of shift report. Per interview, when she started her medication pass, she noticed Resident #2's call light was on frequently, and decided to enter his/her room to she if she could assist the resident. She stated upon entering Resident #2's room, his/her main focus was his/her pain and the fact he/she had not had any medications, including pain medications since arriving at the facility. LPN #2 stated she notified the Director of Nursing (DON) regarding Resident #2's request for pain medication and the DON instructed her to call Pharmacy and confirm when the resident's medications were to be delivered. According to LPN #2, she attempted to obtain a dose of Norco pain medication from the facility's Emergency Drug System with another staff person as her witness, as controlled medications required a witness. However, she stated she was unsuccessful in her attempt to get the Norco medication as the System notified her there were no doses of the medication available to obtain. Further interview revealed if a resident was experiencing pain, such as Resident #2 had been, it could cause adverse effects for the resident like making him/her hypertensive. In addition, she stated at 12:15 AM on 04/18/2021 Resident #2 complained of acute intense abdominal pain and requested to be sent back to the hospital. Interview with CMT #1, on 09/07/2021 at 2:49 PM, revealed she did not recall assisting LPN #2 with attempting to obtain the Norco from the facility's Emergency Drug System on 04/17/2021. She stated however, she had access to the Emergency Drug System for obtaining medications for residents when needed. Continued interview revealed sometimes when she attempted to use the facility's Emergency Drug System it would accept her biometrics (measurement and statistical analysis of people's unique physical and behavioral characteristics, such as fingerprints) and other times it would not, so she was unable to have consistent access to the system. The Surveyor attempted a telephone (phone) interview with Licensed Practical Nurse (LPN) #1 and Certified Nurse Assistant (CNA) #1, who had both been assigned to Resident #2's care on the day of admission. However, all attempts were unsuccessful. Interview with the Executive Director on 09/10/2021 at 2:32 PM, revealed LPN #1 and CNA #1 were no longer were employed by the facility. Interview with the former Director of Nursing (DON), on 09/13/2021 at 9:50 AM, revealed staff should have faxed Resident #2's face sheet and medication orders to the Pharmacy to ensure his/her Physician's Orders for medications were received by the Pharmacy and filled as ordered. She stated pain medication needed to be administered as ordered and requested by the resident. Interview with the former Executive Director (ED), on 09/10/2021 at 1:31 PM, revealed her expectations for a newly admitted resident's medications was for the medications to be available for administration upon his/her admission. Continued interview revealed the facility had processes in place to ensure medications were available for administration to a resident. Per interview, she stated she expected Resident #2 would have received his/her pain medication upon requesting it. The former ED further revealed if the pain medication had not been available she would have expected staff to pull the medication from the facility's Emergency Drug System or have the medication order sent STAT to the local backup Pharmacy. Interview with the Medical Director, on 09/13/2021 at 10:36 AM, revealed his expectations were for staff to administer pain medication as ordered. Per interview, if staff failed to do so, the resident might experience uncontrolled pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the current ED, on 09/10/2021 at 2:32 PM, revealed she expected staff to use the facility's processes which were in place in order to ensure all residents received the things they needed, such as pain medication. The facility alleged it implemented the following actions to remove immediacy: 1. Resident #2 no longer resided in the facility. 2. The ED and DON, notified the Physician of the event and held an ADHOC QAPI meeting on 09/13/2021 to discuss the event and the development of an action plan. 3. The DON/Licensed Nurses completed pain assessments on current residents on or before 09/16/2021. 4. The DON, ADON, UM and/or VPCS reeducated all licensed staff, including agency, by 09/16/2021, regarding pain management to include pain assessments, administering pain medication, and the process for obtaining pain medication from the emergency medication system with a posttest of 100%. Staff not available were reeducated upon return to work. New hires were to be educated in orientation. 5. The facility's Interdisciplinary Team (IDT) was to review all residents in clinical meetings to ensure their pain was managed, pain was assessed and pain medications were available starting 09/17/2021, daily for two (2) weeks. 6. The ED and/or DON were to review audit results weekly for four (4) weeks. 7. The ED and/or DON were to report their findings weekly to the QAPI Committee. The State Survey Agency (SSA) validated the removal plan by: 1. Record review revealed Resident #2 was discharged on [DATE] and was no longer residing in the facility. 2. Review of the facility's documentation revealed an ADHOC meeting was held on 09/13/2021, with the ED, DON, and Physician in attendance. Interview with the ED, DON, and Physician on 09/17/2021, revealed during the ADHOC meeting, the survey findings were discussed and steps were identified to take to lift the immediacy and ensure the identified concerns would not reoccur. 3. Record review revealed pain assessments were completed every shift and documented on the Medication Administration Record (MAR) by the floor nurses on or before 09/16/2021 and were continued. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed the DON and ED audited to ensure all residents had pain assessments every shift. She stated those assessments were reviewed every day to ensure residents' pain was managed, pain interventions were effective and the pain medications were available. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of facility documentation revealed education was provided to all licensed staff on or before 09/16/2021, with a posttest. Continued review revealed certified letters were mailed to employees who had not yet received the education. Interview with the DON, ADON, and Unit Manager (UM), on 09/17/2021, revealed they completed education with licensed staff. Per interview, those staff unable to be reached to come in for the education were sent certified letters, telling them were to be reeducated before returning to work. The DON, ADON and UM stated a posttest was given and reviewed on site with discussion of any concerns/issues. Interview with RN #2 on 09/17/2021 at 1:36 PM, revealed she received education on pain management including assessments, and administering pain medication and was given a posttest. Interview with LPN #5, on 09/17/2021 at 1:27 PM, revealed she was reeducated regarding pain management and assessments and given a posttest. Interview with LPN #3, on 09/17/2021 at 1:13 PM, revealed she was reeducated on pain medication and pain assessments and had a posttest. 5. Review of facility documentation revealed during the facility's clinical meeting the IDT reviewed all residents' pain assessments for completion and to ensure pain medications were available and given as ordered starting on 09/17/2021. Interview with the IDT members, on 09/17/2021 at 10:15 AM and 10:35 AM, revealed they had reviewed pain management of all residents to ensure their pain medications were available and assessments were completed. 6. Review of the audit documentation revealed the ED had been reviewing the audit results daily. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she was reviewing audits more often than what was stated in the facility's Allegation of Compliance (AOC). She stated she had been reviewing them daily. 7. Review of the facility's documentation revealed the ED/DON was to report the audit results to the QAPI Committee weekly. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she had been reviewing the audits and discussing trends and improvements with the QAPI team. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed the QAPI Committee had the first meeting that day and had reviewed and discussed the last two (2) days of QAPI findings.

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	185176	A. Building B. Wing	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Oaks Care and Rehab Center, LLC	446 Mt. Holly Avenue Louisville, KY 40206

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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 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42857 Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure medically related Social Services were provided to attain or maintain the highest practicable physical, mental, or psychosocial well-being for one (1) of nine (9) sampled residents (Resident #1). Interview and record review revealed the facility's Social Services Director (SSD) had been attempting to have Resident #1 transferred to a sister (facilities that are part of the same corporation) facility. However, the facility initiated an Against Medical Advice (AMA) discharge for Resident #1, on 07/19/2021 at the insistence of the facility's Director of Nursing (DON). The SSD felt the resident's discharge was not safe; however, the facility discharged Resident #1, an insulin dependent diabetic, to a local homeless shelter without the resident's medications which included his/her insulin. The facility failed to ensure the resident received the medically related Social Services he/she required for safety. After discharge to the homeless shelter, Resident #1 presented to the hospital on 07/20/2021, with a blood glucose level of 388 mg/dL (milligrams per deciliter), the normal range for an adult was between 70 and 130 mg/dL before meals; and a Potassium level of 6.1 mEq/L (milliequivalents per liter), the normal range for adults was 3.7 to 5.2 mEq/L. The facility's failure to ensure medically related Social Services was provided has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/03/2021 and was determined to exist on 07/19/2021, at 42 CFR 483.15 Admission, Transfer, and Discharge (F624), 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), and 42 CFR 483.40 Behavioral Health Services (F745) at a Scope and Severity of J. The facility was notified of the Immediate Jeopardy on 09/03/2021. The facility submitted an acceptable Allegation of Compliance (AOC) on 09/17/2021 and alleged past noncompliance and removal of immediacy on 07/22/2021. The State Survey Agency validated past noncompliance, as alleged, with removal of immediacy on 07/22/2021. The findings include: Review of the Social Services Director's (SSD) Job Description, undated, revealed the SSD ensured residents and families were assisted with personal and environmental difficulties which predisposed them to illness or interfered with obtaining maximum benefits of their medical care. Continued review revealed the SSD assisted with the following: provision of transfer services for residents; evaluation of residents for discharge potential; provision of comprehensive discharge planning services; coordination of post discharge care and services; and, preparation of the discharge summaries. Record review revealed the facility admitted Resident #1 on 06/30/2021, with diagnoses that included Heart Disease, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Muscle Weakness, Dysphagia, Anxiety, Unsteadiness, Depression, and Hypertension. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #1's State Appointed Guardian (SAG), on 08/23/2021 at 1:04 PM, revealed she became Resident #1's Guardian on 07/01/2021. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have moderate cognitive impairment as indicated by the Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15). Continued review revealed the facility assessed Resident #1 to be frequently incontinent of bowel and bladder. Further review revealed the facility assessed Resident #1 to require insulin injections for his/her diagnosis of Type 2 DM. In addition, the facility assessed the resident as receiving numerous medications to treat his/her other diagnoses. Review of Resident #1's Comprehensive Care Plan (CCP) revealed the facility initiated a discharge care plan for the resident on 07/01/2021, with interventions which included for staff to contact his/her Guardian for discharge planning. Continued review of the discharge care plan revealed staff were to identify any equipment Resident #1 needed while in the facility and determine if the resident would need any follow up appointments. Continued review of the CCP revealed the facility had care planned Resident #1 as at risk for falls related to weakness, and Activities of Daily Living (ADL's) assistance related to weakness and decreased mobility. Further review of the CCP revealed the facility had also care planned Resident #1 for potential nutritional risk and wandering. Review of Resident #1's Progress Note, dated 07/12/2021, revealed Resident #1's seventy-two (72) hour meeting was held with the SSD, Therapy staff and the resident. Continued review revealed Resident #1 was informed he/she needed to continue to work with therapy to gain more independence and continence. Additionally, the Note documented Resident #1 wanted to return to the homeless shelter where he/she previously resided. Interview with the homeless shelter's Director of Programs, on 07/27/2021 at 1:40 PM, revealed the shelter did not provide assistance in any way with medications, including storage or dispensing of medications. Continued interview revealed clients at the homeless shelter had to leave the shelter every day at 7:00 AM and could check-in back in for the evening, starting at 4:00 PM. She stated if the clients left any medications behind when leaving, staff collected the medication which they placed in a locked box. Per interview, the collected medications in the locked box were taken to a local Pharmacy where they were destroyed. Further interview revealed the homeless shelter had no support staff to assist clients with transfers (i.e. to and from a wheelchair), showers, and incontinence care. Interview with the previous SSD, on 08/24/2021 at 9:18 AM, revealed during the morning meeting on 07/17/2021, the DON notified her Resident #1 was leaving AMA that day. The SSD stated she voiced safety concerns regarding Resident #1 needing to be more independent prior to being discharged , and was concerned there was no wheelchair available. Continued interview revealed she knew Resident #1 was able to transfer on his/her own to the toilet and was able to feed himself/herself. The previous SSD stated she was not aware Resident #1 was an insulin dependent Diabetic. Further interview revealed after Resident #1 was discharged AMA to the homeless shelter, she notified Adult Protective Services (APS) of the unsafe discharge. Interview with the Assistant Director of Nursing (ADON), on 05/28/2021 at 3:23 PM, revealed approximately a week prior to Resident #1 leaving AMA, the DON and SSD discussed finding other placement for Resident #1 at another facility which would be able to accommodate the resident's wandering behaviors. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's previous DON, on 08/25/2021 at 1:27 PM, revealed the SSD was notified Resident #1 wanted to leave the facility and she took over the discharge process from the SSD. Continued interview revealed the SSD was responsible for coordinating and facilitating discharge of residents, including ensuring the residents had everything they needed. She stated Resident #1 was given a list of his/her medications at the time of discharge; however, no actual medications were given to him/her to take with him/her. Additionally, she revealed he/she was not given any money to purchase any supplies he/she might need. ` Interview with the previous Executive Director (ED), on 08/26/2021 at 4:30 PM, revealed she had not been made aware Resident #1 was discharged AMA until after the resident had already left the facility. She stated the SSD and clinical team communicated such matters in the facility's morning meeting. Further interview revealed staff in the morning meeting discussed any changes with a resident's discharge plan and the SSD made any updates as needed. Interview with the current SSD, on 09/03/21 at 2:56 PM, revealed her responsibilities were to ensure when a resident was discharged the resident was provided with all the necessary things they needed to maintain their goals and ensure their safety after discharge. She stated if those things were not completed for a resident prior to discharge, something bad could potentially happen to the resident. Interview with the current ED, on 09/03/2021 at 3:23 PM, revealed the SSD and clinical team should always work closely together to ensure a safe discharge for a resident. She stated discharge planning occurred early on to ensure all members of the clinical team were on the same pages regarding goals for the resident to be discharged . The facility alleged it implemented the following actions to remove immediacy: 1. The Regional [NAME] President of Operations (RVPO) and [NAME] President of Clinical Services (VPCS) reeducated the facility's Interdisciplinary Team (IDT) which included the Executive Director (ED), Director of Nursing (DON), Social Services Director (SSD) Dietary Manager (DM), Maintenance Director, Therapy Director, Activity Director, Assistant Director of Nursing (ADON), Human Resources Director (HR), Scheduler, Minimum Data Set (MDS) Coordinator, Assistant Housekeeping Director, and Admission Director on 07/20/2021. The education included the Against Medical Advice (AMA) Policy, AMA form, and the policy on Change in a Resident's Condition/Status (CIC) which included discharge without proper medical authority, and care plan revisions to ensure a safe discharge with a posttest administered. 2. On 07/21/2021, the RVPO and VPCS completed an audit on all current residents to ensure their Guardian status paperwork was in the medical record. 3. On 07/21/2021, the RVPO and VPCS completed an audit of all discharges from 06/01/2021 through 07/21/2021, to ensure proper discharge notification based on guardianship status. 4. The ED, DON, and SSD were no longer employed at the facility effective 07/21/2021. 5. The RVPO completed education to the Liaisons related to ensuring the facility knew about a resident's guardianship status and proper paperwork was provided. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Newly hired management members such as the ED, DON and SSD received education regarding care plans and the facility's discharge process to include CIC, discharge without proper medical authority and care plan revision, with a posttest. 7. Beginning 07/21/2021, any new admissions were to be audited by the IDT for guardianship status and discharge care planning five (5) days week for six (6) months. 8. The ED and/or DON were to review the results of the audits daily. 9. The ED, DON, and/or SSD were to submit results of the audit findings weekly times (x) six (6) months to the facility's Quality Assurance Performance Improvement (QAPI) Committee which was the IDT until the issue was resolved. The State Survey Agency (SSA) validated the removal plan by: 1. Review of facility documentation revealed reeducation was provided to the IDT team with a posttest provided with a completion score of 100% to all IDT members. Interview with the IDT members, on 09/17/2021 10:09 AM, 10:15 AM and 10:35 AM, revealed they received education regarding the facility's AMA policy and the form along with discharge procedures for someone wanting to leave AMA. Interview revealed they had also been educated regarding the care plan updates to ensure a safe discharge. 2. Record review revealed on 07/21/2021, Resident #1's care plan had been updated to reflect his/her guardianship status. Interview with the MDS Coordinator on 09/17/2021 at 12:33 PM, revealed she had updated Resident #1's care plan to reflect his/her guardianship status. 3. Review of facility documentation revealed on 07/21/2021 the RVPO and VPCS completed an audit of all discharges from 06/01/2021 through 07/21/2021 to ensure proper notification based on guardianship status. Interview with the Regional [NAME] President of Operations (RVPO), on 09/17/2021 at 9:20 AM, revealed she completed the audits to ensure no one had been missed, and to ensure the facility had residents who had guardianships were reflected on the resident's medical record. Interview with the [NAME] President of Clinical Services (VPCS), on 09/17/2021 at 2:33 PM, revealed she assisted with the audits and reviewed any guardianship discharges to ensure proper notifications were made as required. 4. Interview with the previous ED, DON and SSD revealed they were no longer employed at the facility. 5. Review of facility documentation revealed the facility's liaisons were educated regarding ensuring the facility was made aware of residents' guardianship status and that the facility received the proper paperwork. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's Liaison #1, on 09/17/2021 at 9:30 AM, revealed she completed education regarding: if a resident was coming to the facility and had a Guardian she was to notify the facility of who the Guardian was, and they would contact the Guardian. She stated the education also included the facility reaching out to a resident's Guardian to ensure the correct paperwork was provided and signed. Interview with the facility's Liaison #2, on 09/17/2021 at 9:55 AM, revealed she had education provided regarding receiving the appropriate guardianship paperwork and ensuring the facility was aware. Interview with the facility's Liaison #3, on 09/17/2021 at 9:34 AM, revealed she was educated regarding if she received a referral for a new resident and it was noted they had a Guardian, paperwork must be requested and identify the Guardian contact. Further interview revealed Liaison #3 stated the liaisons let the facility know the Guardian information which included the SSD. Interview with the facility's Liaison #4, on 09/17/2021 at 9:37 AM, revealed she completed education regarding the process of ensuring guardianship paperwork was clarified and the guardianship status of a resident was relayed to the facility. 6. Review of facility documentation revealed newly hired management members, the ED, DON and SSD received education on care plans and the discharge process. Interview with the ED and DON, on 09/17/2021 at 2:06 PM, revealed education was completed on the day of hire with completion a posttest which was reviewed and any questions discussed. 7. Review of facility documentation revealed audits were completed starting 07/21/2021 on new admissions for guardianship status and discharge care planning. Interview with the IDT members, on 09/17/2021 at 10:09 AM, 10:15 AM and 10:35 AM, revealed new admissions were being reviewed in the facility's clinical meeting for guardianship status and discharge care plans. 8. Review of facility documentation regarding the audits performed revealed the ED had been reviewing the audit results daily. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she had been reviewing the audits daily. 9. Review of facility documentation revealed the ED or DON would report the audit results to QAPI weekly. Interview with the ED, on 09/17/2021 at 2:11 PM, revealed she had been reviewing the audits and discussing trends and improvements with the QAPI team members. Interview with the DON, on 09/17/2021 at 2:33 PM, revealed the QAPI meeting had been discussing trends and improvements based on the audit findings. Interview with the QAPI Committee members, on 09/17/2021 at 10:15 AM and 10:35 AM, revealed they reviewed the audit results and discussed improvements.