STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366207	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terrace Rehabilitation and Nursing Center	1520 Hawthorne Avenue Columbus, OH 43203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, closed medical record review, staff interview, family interview, United Health Care (UHC) transportation representative interviews, review of accuweahter.com information and review of the facility policy and procedures titled Discharge Summary and Plan and Discharge Medications, the facility failed to ensure a safe and orderly discharge for one resident (Resident #76), who had diagnoses of dementia, opioid abuse, alcohol abuse and history of elopement, when the resident was discharged to another skilled nursing facility on 06/07/22. This resulted in Immediate Jeopardy, on 06/07/22 at approximately 5:00 P.M. when the facility arranged for transportation for Resident #76 to be taken to another long-term care facility for long term care placement. Prior to the resident's pick-up, there was no written evidence facility staff had communicated the specific details of Resident #76's transfer, his care needs or medication status to the receiving facility. Information obtained from the receiving facility revealed on 06/07/22 at approximately 6:15 P.M. Housekeeping Supervisor (HS) #139, whose shift had ended and who was leaving the facility, found Resident #76 in the facility parking lot without any staff present and without identification or discharge paperwork. The resident was able to state his name and was taken into the facility. Resident #76 was found to have 20 to 30 Suboxene strip medications (opioid medication for sublingual administration), alcohol and illegal drug paraphernalia, including a burning spoon and torch on his person. The risk for actual harm, injury or death occurred as Resident #76 had the potential to wander from the premises without staff knowledge, the resident had access to the medication Suboxene, which could have been self-administered or due to the effects of being left outside with a weather temperature of 78 degrees with rain on that date. This affected one resident (#76) of three residents reviewed for transfer/discharge. On 06/27/22 at 5:02 P.M. Regional Director of Operations #165, Administrator #145 and [NAME] President of Clinical Operations #220 were notified Immediate Jeopardy began on 06/07/22 when the facility failed to provide a safe and orderly discharge to another skilled nursing facility for Resident #76, who was transferred and left in the parking lot of the receiving skilled nursing facility with no evidence the resident's discharge and care needs/medication status were communicated by the discharging facility to the receiving facility. The Immediate Jeopardy was removed on 06/29/22 when the facility implemented the following corrective actions: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Bella Terrace Rehabilitation and Nursing Center	1520 Hawthorne Avenue Columbus, OH 43203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/27/22 at 6:45 P.M. [NAME] President of Clinical Operations (VPCO) #220 in-serviced all department heads, including Director of Nursing (DON) #150, Receptionist #346, Dietary Director #336, Unit Managers #329, #344 and #362 Admissions Director #334, Administrator #145, Maintenance Director #323, Staff Scheduler #375, Social Service Director #160, Human Resource Director #310, Activity Director #348 and Housekeeping Supervisor #337 on the requirements for a safe and orderly resident discharge, including discharge medications, the Discharge Summary and Plan policy and also on the need to ensure when a resident was picked up by transport, the receiving facility was to be notified so they knew when to expect the resident. On 06/27/22 at 6:45 P.M. Admissions Director #334 reviewed all resident discharges from 06/08/22 to 06/27/22 to ensure safe and orderly discharge was completed. No concerns were identified by the facility. Resident #61 was identified as the only resident discharged during this time period. On 06/27/22 at 6:51 P.M. Regional Clinical Consultant #460 reviewed resident records related to discharges to ensure the discharges were safe and orderly. Residents #3, #50, #52, #59, #61, #64, #67 and #72 were reviewed with no concerns identified by the facility. On 6/28/22 at 10:00 A.M., Social Service #485, Regional Director of Operations #165 and Regional Director of Business Development #210 provided additional in-service training to all department heads on the requirements for a safe and orderly discharge, including discharge medications, the Discharge Summary and Plan policy and on the need to ensure that when resident was picked up by transport, the receiving facility was notified so they know when to expect the resident. On 06/28/22 by 10:05 A.M. the facility Interdisciplinary Team (IDT), including DON #150, Receptionist #346, Dietary Director #336, Unit Managers #329, #344 and #362 Admissions Director #334, Administrator #145, Maintenance Director #323, Staff Scheduler #375, Social Service Director #160, Human Resource Director #310, Activity Director #348, Housekeeping Supervisor #337 and Medical Director #450 reviewed the records of eight residents (Resident #3, #50, #52, #59, #61, #64, #67, and #72) who had been discharged or were pending discharges (as of this date) to ensure discharge planning and paperwork was complete/up to date to ensure a safe and proper discharge occurred for each resident. On 06/28/22 by 10:30 A.M. [NAME] President of Clinical Operations #220 and Department Heads (DON #150, Receptionist #346, Dietary Director #336, Unit Managers #329, #344 and #362 Admissions Director #334, Administrator #145, Maintenance Director #323, Staff Scheduler #375, Social Service Director #160, Human Resource Director #310, Activity Director #348 and Housekeeping Supervisor #337) in serviced all nursing staff on safe and orderly discharges, including discharge medications, discharge summary, report to receiving facility/location and also on need to ensure that when resident was picked up by transport, the receiving facility was notified so they knew when to expect the resident. The training included three registered nurses (RNs), 23 licensed practical nurses (LPNs) and 38 state tested nursing assistants (STNAs) and was done either one on one, verbally in group or via telephone. As of 06/28/22 all nursing staff had been educated. On 06/28/22 by 12:00 P.M. Regional Clinical Consultant #460 contacted the transport company used to transport Resident #76 on 06/07/22, regarding the procedure for transporting a resident from the facility. The facility requested all transportation from this company now include a safe handoff to the receiving location, and that if that cannot be accomplished for some reason, to immediately contact the transferring facility. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 06/28/22 the facility implemented a plan for Administrator #145, DON #150, Regional Director of Operations #165, or [NAME] President of Clinical Operations #220 to review all discharges for the next 30 days prior to the resident leaving the facility to ensure discharge planning was completed, and the receiving location was aware and expecting the resident. Findings will be reported to the QAPI Committee (RDO #165, VPCO #220, Social Service #485, RCC #465, Regional Director of Business Development #210, DON #150, UM #329 and #362, MD #450, [NAME] Present of Operations #500, Director of Rehabilitation #510 and Admissions #334). If any concerns are identified during the 30 days, the review will continue for a longer period of time. On 06/28/22, an ad HOC QAPI meeting was held with the Medical Director #450 and above QAPI committee members to discuss the issue and the above plan. On 06/29/22 VPCO #220 provided a newly created document tool for staff to enter information regarding resident transfers including the name/date/time of staff contacted (at the receiving facility), the date/time the resident left the facility and any pertinent communication regarding the specifics of the transfer. The document will be reviewed daily by DON #150 and/or designee and will become part of the resident's permanent electronic medical record. On 06/29/22 from 11:45 A.M. to 12:08 P.M. interviews with Licensed Practical Nurse (LPN) #306, #313, #362 and State Test Nursing Assistant (STNA) #322 and #361 revealed the staff interviewed had been educated and were knowledgeable on the newly implemented facility discharge procedures. Although the Immediate Jeopardy was removed on 06/29/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings Include: Review of Resident #76's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] to a sister skilled nursing facility. Resident #76 had diagnoses including encephalopathy, severe protein-calorie malnutrition, aphasia, cerebral infarct, opioid dependence, alcohol dependence, laceration of part of head, muscle wasting, unsteadiness on feet and difficulty in walking. Record review revealed Resident #76 resided on the secured/locked unit of the facility. Record review revealed the resident was admitted for long term care placement. Review of the resident's plan of care revealed no discharge plan of care had been developed for the resident. Review of the resident's physician medication orders revealed the resident had an order for the Schedule III narcotic, Suboxene (a medication used as a maintenance treatment of opioid dependence) 8-2 milligrams (mg), to be administered by staff, one film sublingually two times per day for dependency. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 05/30/22 revealed Resident #76 had clear speech, usually understood others, usually made himself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of 12 (out of 15). The assessment indicated the resident had not displayed any behaviors during the review period and required staff supervision for bed mobility, transfers and ambulation. Review of the plan of care, dated 06/03/22 revealed the resident resided on a secure unit related to exit seeking behaviors, dementia and poor decision-making skills. Interventions included encourage to attend activities of interest, monitor for exit seeking behavior and document occurrences, provide activities of interest and secure unit as physician ordered. Review of the plan of care, dated 06/03/22 revealed the resident had impaired cognitive function/dementia or impaired thought process related to difficulty making decisions and head injury. Interventions included administer medications as ordered and observe for side effects and effectiveness, use the resident's preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact and reduce any distractions. The plan of care revealed the resident understands consistent, simple directive sentences and to monitor/document/report any changes in cognitive function. Review of a progress note dated 06/01/22 at 7:10 P.M. revealed Resident #76 went out of the building and per staff the resident was found in [NAME] Park (approximately one block away) without injury. The note revealed the Director of Nursing (DON), Administrator and physician were made aware. A facility investigation of the incident documented a staff member was present with the resident during the time he was out of the facility and at the park on this date. Review of a progress note dated 06/06/22 at 4:15 P.M. revealed Resident #76 was found spray painting his bedroom floor. The note indicated spray paint and a bottle of alcohol was confiscated from the resident at that time. The resident was educated on the facility's policy regarding alcohol and the resident voiced understanding. A facility investigation revealed the facility believed the spray paint and alcohol were brought into the resident from a visitor. Review of the progress note dated 06/07/22 at 2:25 P.M. and authored by Administrator #145 revealed she spoke with Resident #76's father and informed him the resident would be transferring to another skilled nursing facility within the company today (06/07/22) due to behaviors. The entry documented the resident's father was agreeable to transfer. Review of a progress note dated 06/07/22 at 5:59 P.M. and authored by Agency Nurse #205 revealed Resident #76 was discharged to another facility. The note failed to contain any additional information regarding the discharge/transfer. There was no documentation related to the actual time the resident left the facility, no documentation of communication to the receiving facility, no documentation related to transportation and no documentation of what information/belongings were transferred with the resident. Review of a late entry progress note, dated 06/09/22 at 3:00 P.M. (effective for 06/07/22 at 8:56 P.M.) and authored by DON #150 revealed the patient's medications were taken to the receiving facility this evening, report was given to accepting nurse. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #76's physician's orders revealed no order to transfer/discharge the resident was obtained prior the resident's discharge. Review of a document titled Discharge Plan of Care and Recapitulation, dated 06/07/22 at 12:56 P.M. and authored by Social Service Director (SSD) #160 revealed under the nursing services section was a handwritten entry, personally took medications from facility to facility 06/07/22. The section was signed by DON #150. Further review revealed the document was incomplete of the recapitulation of the resident's stay at the facility. On 06/27/22 at 9:38 A.M. interview with Administrator #145 revealed Resident #76 resided on the facility secured care unit (due to cognitive impairment and behaviors). The Administrator verified the resident had walked off from the facility on 06/01/22 and the decision was made, following that incident, to discharge/transfer the resident to a sister facility that was more secure. On 06/27/22 at 10:55 A.M. interview Administrator #145 revealed SSD #160 had spoken with the unit manager (UM) and Former Administrator (FA) #140 of the receiving facility to inform them Resident #76 was being transferred to their facility. Administrator #145 indicated the communication was done verbally and denied having any written documentation of the specific details of the transfer or communication that occurred. On 06/27/22 at 11:24 A.M. interview with Regional Director of Operations (RDO) #165 revealed on 06/07/22 he called Former Administrator #140 (of the receiving facility) and verbally informed him Resident #76 was being transferred to the facility but did not have an estimated time of arrival. RDO #165 revealed Former Administrator #140 later contacted him, alerting him the resident was dropped off in the parking lot and had home medications including Suboxene strips and drug paraphernalia on his person. RDO #165 revealed they used the resident's insurance company transportation service and to his knowledge the company provided medically trained staff for transportation. On 06/27/22 at 1:17 P.M. interview with UHC Transportation Representative #200 (a representative from the resident's insurance company) revealed Resident #76 was transported from the facility on 06/07/22 by their contracted transportation company. The representative revealed the resident's pick-up time was scheduled for 5:00 P.M. and indicated the driver would have called the facility approximately 15 minutes within the actual scheduled pick-up time to confirm the pick-up, but denied the driver was required to call the facility the resident was being dropped off to (as they provided non-emergency medical transportation). The representative revealed unless specifically indicated or if the facility had reported the resident was cognitively impaired when transportation was booked, the resident would simply be dropped off and the transportation company would not provide door to door or hand to hand assistance during transport. The representative revealed there would be no way for the transportation driver to walk the resident to the door or alert the receiving facility the resident was there. The driver would go by any notes entered at the time of the booking. No specific notes of the booking were provided during the call. However, the representative revealed she had no indication Resident #76 needed anything more than dropped off. On 06/27/22 at 3:12 P.M. telephone interview with Resident #76's father revealed he was agreeable with the resident's transfer as he felt the new facility would be more secure and prevent the resident from leaving without staff knowledge. However, the resident's father revealed he was unaware of when his son was actually going to be moved to the new facility as this had not been communicated to him. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/28/22 at 12:45 P.M., interview with DON #150 verified on 06/07/22 a discharge summary had not been sent with Resident #76 to the receiving facility nor was there any evidence of report being called or the specifics of Resident #76's transfer being completed/documented prior to or at the time of discharge. DON #150 revealed she personally transported the resident's prescription medications, at approximately 9:00 P.M. that evening to the receiving facility as written on the resident's discharge summary. She said at that time she also provided the receiving facility with a copy of the discharge summary, the resident's history and physical and physician's orders. On 06/28/22 at 1:28 P.M. interview with Agency Nurse #205 revealed she was on duty on 06/07/22 and participated in discharging Resident #76 to the receiving facility. She indicated the resident was sent with his belongings and she had been told by Administrator #145 all required paperwork had been faxed to the receiving facility. Agency Nurse #205 revealed she had been notified on 06/07/22 about an hour or two before the resident left the facility of the transfer and indicated multiple staff members and the resident were packing the resident's belongings. Agency Nurse #205 revealed the resident had a lot of belongings and staff did not go through all of the belongings. Review of accuweather.com information revealed on 06/07/22 a weather temperature of 78 degrees with rain on that date. On 06/29/22 at 9:05 A.M. telephone interview with Representative #460 from the UHC contracted transportation company verified Resident #76 was transported by their company on 06/07/22 from the facility to another long-term care facility. Representative #460 revealed Resident #76 was picked up at the facility by a Dodge Grand Caravan at 4:29 P.M. and dropped off at the receiving facility at 5:41 P.M. Representative #460 revealed the transportation company provided non-emergency medical transport and the drivers had no formal medical training. Representative #460 revealed the company does not alert the receiving facility of the member being dropped off, especially if they were ambulatory because they just provide transportation. Representative #460 revealed the driver who transported Resident #76 was no longer employed by the company (last date worked 06/15/22), the representative did not provide a reason for the driver no longer being employed. Review of the facility policy titled, Discharge Summary and Plan, dated 12/2016 revealed when a resident discharge was anticipated, a discharge summary and post-discharge plan would be developed to assist the resident to adjust to his/her new living environment. The discharge summary would include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's current diagnoses, medical history, course of illness, treatment and/or therapy since entering the facility, current laboratory, radiology, consultation and diagnostic test results, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status and medication therapy. A copy of an evaluation of the resident's discharge needs, post discharge plan and the discharge summary would be provided to the resident and receiving facility. Review of the facility policy titled, Discharge Medication, dated 12/2016 revealed unless otherwise specified by facility policy, or contrary to current law or regulations, medications shall be sent with the resident upon discharge. Controlled substances may not be released to the resident upon discharge. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prior to the above onsite investigation, on 06/24/22 an onsite complaint investigation was conducted at the receiving facility, Country Lane Gardens Rehab and Nursing Center in regards to the status and admission of Resident #76 on 06/07/22. The following information was obtained on 06/24/22: On 06/24/22 at 9:10 A.M. interview with the receiving facility's Director of Nursing (DON), DON #157 revealed on 06/07/22 the facility received an admission (identified to be Resident #76) from the above/discharging facility. DON #157 revealed the discharging facility, [NAME] Terrace Rehabilitation and Nursing Center arranged for the resident's transportation and had the resident dropped off. DON #157 revealed Resident #76 was found in the facility parking lot (time not provided) with no communication to them of the transfer or the resident's care or medication needs. She said Resident #76 was subsequently admitted to the facility secure care unit on the second floor due to cognitive impairment and exit seeking behaviors. On 06/24/22 at 9:27 A.M. interview with receiving Unit Manager (UM) #128 (the UM of the secure care unit) revealed Former Administrator #140 notified her Housekeeping Supervisor (HS) #139 found Resident #76 outside the facility when she was leaving her shift. UM #128 revealed whoever transported the resident just unloaded him and left. UM #128 revealed the facility was aware the resident was going to be admitted but were not aware of the actual date/time of when the resident was coming or of any actual transportation arrangements being made. During the interview, UM #128 revealed the resident had a spoon that had been bent and a torch (used for illegal drug use) and Suboxene medications in his belongings when they went through them after his arrival. UM #128 revealed the resident was very confused and had a history of intravenous (IV) drug use. On 06/24/22 at 10:33 A.M. a call was placed to [NAME] Terrace Rehabilitation and Nursing Center to obtain additional information regarding the transfer of Resident #76. The discharging facility's DON, DON #150 verified Resident #76 had been transferred but stated she was unaware of any details related to the transfer. DON #150 revealed Administrator #145 and SSD #160 made all arrangements for the discharge. She said SSD #160 arranged for transportation for Resident #76. DON #150 revealed she transported the resident's medications to the receiving facility after she left work on 06/07/22 (time not provided). DON #150 revealed at that time, she had been notified (by staff at the receiving facility), Resident #76 had medications (Suboxene) on his person when he arrived. DON #150 verified medications were not to be given to confused residents and that was why she transported the resident's (facility prescribed) medications to the receiving facility. DON #150 revealed she had also been notified, at that time that Resident #76 had been left in the parking lot by the transportation service and in addition to the medication, he had drug paraphernalia. On 06/24/22 at 10:48 A.M. interview with Licensed Practical Nurse (LPN) #144, who was employed by the receiving facility revealed she came to work on 06/07/22 at approximately 7:00 P.M. LPN #144 revealed at approximately 6:15 P.M. that day, Resident #76 was found outside the facility, standing with bags and boxes of his belongings. The LPN revealed HS #139 had brought the resident in the facility because the resident told her he was supposed to live at the facility. LPN #144 revealed the discharging facility just did a drive by and dropped him off. The LPN revealed the resident had 20 to 30 Suboxene strips, a torch, burning spoon and marijuana with tobacco mixed in it found in his personal belongings. The LPN said Resident #76 had no discharge instructions or identification. LPN #144 revealed she immediately contacted the Administrator (Former Administrator #140) and asked him to come to the facility (he had left for the day) to address the medications that were found with the resident. LPN #144 revealed DON #150 arrived at the facility later that night, around 11:00 P.M. with the resident's prescription medications. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/24/22 at 11:09 A.M. interview with the [NAME] Terrace Rehabilitation and Nursing Center Administrator, Administrator #145 revealed on 06/07/22 Resident #76 was discharged from the facility and transported by United Health Care (UHC) transportation service to Country Lane Gardens Rehab and Nursing Center. Administrator #145 denied knowledge the resident was dropped off in the parking lot or of the receiving facility being unaware of his arrival. Administrator #145 denied knowledge of the resident being transferred with Suboxene or illegal drugs/paraphernalia on his person. Administrator #145 revealed Social Service Director (SSD) #160 had been in communication with the receiving facility. Resident #76 was being transferred from the facility due to extensive behaviors and finding spray paint and alcohol in his room during room sweeps. On 06/24/22 at 11:38 A.M. interview with the receiving facility's Admission Coordinator, (AC) #101 revealed on 06/07/22 at 10:12 A.M. she received an email correspondence from the discharging facility indicating Resident #76 was pending authorization for transfer. AC #101 revealed she received a second email from corporate office approving the transfer pending the insurance authorization. AC #101 revealed there was never a specific date or time for the resident's transfer received from the discharging facility. On 06/24/22 at 12:09 P.M. interview with Housekeeping Supervisor (HS) #139 revealed on 06/07/22 after 6:00 P.M. at the end of her shift when she was leaving the facility, she noticed a man standing at the edge of the parking lot with his belongings. HS #139 revealed she was being picked up by her husband and her husband reported to her a (personal type) vehicle had pulled up, got the man and his stuff out of it and then drove off. HS #139 revealed her husband reported no one, neither the transportation driver or man himself, went to the door or into the facility. HS #139 revealed the man (later identified to be Resident #76) did not have any identification on him and she immediately contacted AC #101 and Former Administrator #140. HS #139 revealed she saw medications in the resident's belongings but did not know what they were. On 06/24/22 at 12:29 P.M. interview with discharging facility SSD #160 revealed he contacted Resident #76's insurance company on 06/07/22 at approximately 3:30 P.M. and then set up transportation to the receiving facility. SSD #160 revealed he spoke with a unit manager (UM) regarding a transfer for Resident #76, but could not recall the name of the UM he spoke to. SSD #160 revealed transportation was arranged through the resident's insurance and he assumed the transportation company would make sure the resident got to where he needed to go. SSD #160 revealed the DON took the resident's prescription medications to the receiving facility later that day (06/07/22). On 06/24/22 at 1:45 P.M. Resident #76 was observed sitting in a lounge area on the secured unit. An attempt to interview the resident was unsuccessful as the resident was focused on obtaining a cigarette to smoke and unable to be redirected to answer interview questions. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/24/22 at 2:22 P.M. interview with receiving facility Former Administrator (FA) #140 revealed he was driving home from work on 06/07/22 when the housekeeping supervisor called him and asked him if he knew about the guy standing in the parking lot with his boxes. FA #140 revealed he immediately thought of a referral from a sister facility that had been talked about but stated nothing had been confirmed and no date or time of transfer had been set-up. FA #140 revealed he then contacted Regional Director of Operations (RDO) #165 and [NAME] President of Clinical Operations (VPCO) #220 to inquire why the resident was left in the facility's parking lot. FA #140 again voiced, the transfer had been approved but no date or time of transfer had been arranged. FA #140 revealed LPN #144 then called him with concerns of the resident having Suboxene and drug paraphernalia found in his personal belongings. FA #140 revealed he returned to the facility and did take photographs of the items found in Resident #76's possession. On 06/29/22 at 8:52 A.M. observation of the pictures taken by FA #140 of the items found on Resident #76 on 06/07/22 revealed they included a baggie of marijuana, a medication planner with Suboxene strips, a torch (commonly used to heat/dissolve illegal substances), a bottle of Chloroseptic spray, an unlabeled pill bottle with a bent spoon in it with half of white pill on the spoon and a bottle of mouthwash. This deficiency substantiates Complaint Number OH00133684.