STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. Building B. Wing	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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** 40537 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1), who was unable to walk, was incontinent (unable to voluntarily control) of bowel and bladder functions, and was dependent on staff for activities of daily living (ADLs, such as bed mobility, transfers, dressing, toilet use, bathing, and personal hygiene), was free from neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress). On 4/27/22, around 5 pm, after returning to the facility from conducting personal business at the Department of Motor Vehicles (DMV) and without prior notice and preparation, Resident 1 was discharged against medical advice (AMA) because the resident left with a friend to the DMV and the physician (MD 2) had cancelled (discontinued) the order given earlier the same day to go out on pass (OOP, being temporarily absent from the facility). As a result, Resident 1 spent the night alone at an empty apartment without food, air conditioning, and telephone to call for help, sitting in his wheelchair soaked in urine and feces (bowel movements or stool), and was found by a friend and Family Member 1 (FM 1) on the floor the following day (4/28/22) around 1 pm, crying, hungry, thirsty, soiled, scared, embarrassed, in pain, helpless, and was traumatized. On 7/15/22 at 12:06 pm, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) situation under 42CFR S483.12 Freedom from Abuse, Neglect, and Exploitation. The Administrator (ADM), the Assistant Director of Nursing (ADON), and the Social Services Director (SSD) were notified of the IJ situation from the facility ' s failure to ensure Resident 1 was free from neglect. On 7/16/22 at 12:00 pm, the IJ situation was removed in the presence of the ADM, while onsite, after verifying the implementation of the facility ' s submitted and accepted IJ Removal Plan. The IJ removal plan included the following summarized actions: 1. The facility attempted to contact Resident 1 and their representative to invite him to return to the facility or to assist Resident 1 with being admitted to another facility. (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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(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	2. The SSD, ADM, and ADON reviewed all residents ' records with planned discharge/transfer to ensure compliance with regulatory requirements. 3. The SSD provided training to the ADM, the ADON, and three physicians on the facility ' s policies and procedures pertaining to discharging residents, resident rights, and resident neglect. 4. The facility created a discharge procedure checklist and discharge documentation auditing program to ensure all discharge planning is completed before a resident is discharged from the facility. 5. Training to all social services and nursing staff regarding the facility ' s discharge documentation auditing program, discharge procedures, resident rights, and resident neglect. Cross-reference F622, F623, and F624. Findings: A review of Resident 1 ' s Admission Record (Face Sheet), dated 6/24/22, indicated the facility admitted Resident 1, a [AGE] year-old male, on 11/19/21 with diagnoses includingparaplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), accidental discharge from unspecified firearms or gun, broken mandible (jaw), fracture of the first rib and thoracic vertebra (in the middle section of the spine), and generalized muscle weakness. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/26/21 and 2/26/22, indicated the resident was able to communicate, remember, comprehend, and make decisions. Resident 1 was incontinent (unable to voluntarily control) of bowel and bladder functions, was totally dependent on staff for transferring in and out of his bed, with toilet use, personal hygiene, dressing, and bathing/showering. Resident 1 was unable to walk and required a wheelchair for mobility. A review of Physician ' s Orders for Resident 1, dated 4/27/22, indicated the resident may go OOP with responsible party for personal business. The same day the order was discontinued. A review of Resident 1's Health Status Note, written by Licensed Vocational Nurse 9 (LVN 9), dated 4/27/22, indicated Resident 1 returned to facility asking for medication to be sent with him for AMA discharge. The physician (MD 3) was contacted to notify of resident's discharge AMA and to obtain authorization to give the resident his medications upon discharge. MD 3 gave the okay to discharge Resident 1 AMA with all remaining medication. Resident 1 was discharged AMA, via wheelchair, accompanied by family, and with all remaining medications. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/8/22, at 2:37 pm, during an interview with MD 2 and concurrent review of the Physician ' s Orders, MD 2 stated that originally Resident 1 had an order to go OOP to the DMV on 4/27/22 but the order was discontinued hours later the same day (4/27/22). MD 2 stated he did not personally give or discontinue Resident 1 ' s order to go OOP on 4/27/22 to the DMV. MD 2 stated a resident must have a physician's order to leave the facility, and he and the other physicians in his physician's group (MDs 1 and 3) give OOP order or deny such order if they think a resident would not be safe outside the facility. MD 2 stated MDs 1 and 3 suspected Resident 1 was doing drug-related activities and that was the reason the why they canceled Resident 1 ' s OOP order. MD 2 stated that to his knowledge, Resident 1 did not have a drug test confirming the suspected drug-related activities and did not have documented safety concerns for Resident 1 go OOP. MD 2 stated he did not give a discharge order. MD 2 stated there was no immediate plan to discharge Resident 1. On 7/12/22 at 10:40 am, during an interview, Resident 1 stated that on 4/27/22, he and a family friend (FF 1) went to the DMV and returned to the facility around 4 pm. After the staff assisted him with incontinent care, a staff told him he had to leave the facility immediately because he went to the DMV without permission from a physician. Resident 1 stated FF 1 wheeled him out at 5 pm. Resident 1 stated he felt messed up, it's like I knew I wasn't ready to leave the facility for good. They knew I had nowhere to go at the time, but they didn't care what was going to happen to me. Resident 1 stated Resident 2 offered him to stay at his place and FF 1 and another friend brought him to the apartment, located on a second floor. Thefriends were not able to put him in bed because the hospital bed in the apartment was too high. The friends left to go to work, and he stayed alone. Resident 1 stated he could not reach cups to serve water from the faucet to drink from because they were in high cabinets, and he had to drink from a faucet in the bathroom using his hand. Resident 1 stated his cellphone was broken and he could not call anybody for help, he was scared and helpless. There was no food or air conditioning in the apartment. Resident 1 said he had nothing to eat the evening of 4/27/22 and spent the entire night in his wheelchair soiled and wet. Resident 1 stated that Resident 2 informed Family Member 1 (FM 1) where he was. The following day, 4/28/22, at 1 pm, FM 1 and a friend came to rescue him. Resident 1 stated he was embarrassed, afraid, hungry, thirsty, in pain, and traumatized. On 7/12/22, at 11:35 am, during an interview, Resident 2 (Resident 1 ' s roommate) stated that on 4/27/22, after the facility did not allow Resident 1 to return, he gave him permission to stay in his vacant apartment which had a hospital bed. The following day after not being able to contact Resident 1 by phone, he called FM 1. On 7/12/22, at 3:30 pm, during an interview, Case Manager (CM) stated on 4/27/22 she became aware that Resident 1 had a physician ' s order to go OOP to the DMV, but prior to 4/27/22, MD 3 had told her that Resident 1 should not have any more orders to go OOP due to safety concerns and on 4/27/22, she called MD 3 to clarify Resident 1 ' s OOP order. MD 3 told her to cancel the order which she did and notified the ADM. CM stated she did not know what the safety concerns were. CM 1 stated she did not provide Resident 1 with a discharge assessment, a notice of discharge, or a discharge care plan. On 7/12/22, at 3:40 pm, during an interview, the ADM stated on 4/27/22, CM informed him that a physician had canceled Resident 1 ' s order to go OOP to the DMV due to safety concerns. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/13/22, at 12:40 pm, during an interview, FM 1 stated the facility did not inform her they were discharging Resident 1 on 4/27/22. FM 1 learned the following day (4/28/2022) about the discharge of Resident 1 after she called the facility, and the nurse told her Resident 1 was gone and did not know where he went. FM 1 stated she felt upset and scared not knowing where Resident 1 was, and then Resident 2 called her and informed her Resident 1 was in his apartment. FM 1 stated she did not have a car and so she asked a friend of hers to go check on Resident 1. FM 1 stated the friend found Resident 1 in Resident 2 ' s apartment but Resident 1 could not get to the door because he had fallen and was crying. FM 1 stated the friend went to pick her up and both returned to Resident 2 ' s apartment where Resident 1 was on the floor, crying, wet with urine and soiled with feces. FM 1 crying stated she felt awful seeing Resident 1 soaking wet and with feces all over his back. FM 1 stated Resident 1 was too traumatized to go back to a facility. He (Resident 1) won ' t even go to a hospital because he thinks they'll make him go to another place like that (the facility) and he ' s (Resident 1) too scared. On 7/13/22, at 5 pm, during an interview, MD 1 stated residents require a physician's permission to leave the facility. MD 1 stated discharge AMA applied to residents leaving OOP without a physician's permission and was a justification for immediate discharge from the facility. MD 1 stated MD 2 ordered the discharge AMA. On 7/15/22, at 12:30 pm, during an interview, the SSD stated the facility did not provide a safe discharge to Resident 1. On 7/15/22, at 1 pm, during an interview, SSD stated the facility did not ask Resident 1 to sign the form for Discharge AMA as per policy. SSD stated Resident 1 did not request to be discharged AMA. On 4/27/22, Resident 1 went to the DMV and when he returned to the facility staff told him he had to leave immediately. On 7/15/22, at 2:50 pm, during an interview with the ADM and concurrent review of the facility ' s policy on Discharge AMA, the ADM stated Resident 1 was not provided with the Form A - Discharge Against Medical Advice for him to sign. A review of the facility ' s policy titled, Abuse Prevention and Prohibition Program, dated 6/1/21, indicated, Purpose to establish, operationalize, and maintain an Abuse Prevention and Prohibition Program designed to ensure . the prevention . of . neglect, mistreatment . in accordance with federal and state requirements . Policy I. Each resident has the right to be free from mistreatment, neglect . V. Identification A. The Facility provides Facility Staff with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect: .f. inadequate provision of care g. Caregiver indifference to resident ' s personal care and needs . i. Leaving someone unattended who needs supervision

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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	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** 40537 Based on interview and record review the facility failed to permit one of five sampled (Resident 1) to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary and appropriate (needs could not be met at the facility, for safety of the resident or others, the resident no longer needs the services provided by the facility, or lack of payment) and failed to ensure the physician documented in Resident 1 ' s clinical record the basis of the transfer as per facility ' s policy on Transfer and Discharge. On 4/27/22, around 5 pm, after returning to the facility from conducting personal business at the Department of Motor Vehicles (DMV) and without prior notice, Resident 1 was discharged against medical advice (AMA) because the resident left with a friend to the DMV and the physician (MD 2) had cancelled (discontinued) the order given earlier the same day to go out on pass (OOP, being temporarily absent from the facility). As a result, Resident 1 spent the night alone at an empty apartment without food, air conditioning, and telephone to call for help, sitting in his wheelchair soaked in urine and feces (bowel movements or stools), and was found by a friend and Family Member 1 (FM 1) on the floor the following day (4/28/22) around 1 pm, crying, hungry, thirsty, soiled, in pain, scared, embarrassed, helpless, and was traumatized. On 7/15/22 at 12:06 pm, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) situation under 42CFR S483.15(c) Transfer and discharge. The Administrator (ADM), the Assistant Director of Nursing (ADON), and the Social Services Director (SSD) were notified of the IJ situation from the facility ' s failure to ensure Resident 1 was permitted to remain in the facility. On 7/16/22 at 12:00 pm, the IJ situation was removed in the presence of the ADM, while onsite, and after verifying the implementation of the facility ' s submitted and accepted IJ Removal Plan. The IJ removal plan included the following summarized actions: 1. The facility attempted to contact Resident 1 and their representative to invite him to return to the facility or to assist Resident 1 with being admitted to another facility. 2. The SSD, ADM, and ADON reviewed all residents ' records with planned discharge/transfer to ensure compliance with regulatory requirements. 3. The SSD provided training to the ADM, the ADON, and three physicians on the facility ' s policies and procedures pertaining to discharging residents, resident rights, and resident neglect. 4. The facility created a discharge procedure checklist and discharge documentation auditing program to ensure all discharge planning is completed before a resident is discharged from the facility. 5. Training to all social services and nursing staff regarding the facility ' s discharge documentation auditing program, discharge procedures, resident rights, and resident neglect. (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 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross-reference F600, F623, and F624. Findings: A review of Resident 1 ' s Admission Record (Face Sheet), dated 6/24/22, indicated the facility admitted Resident 1, a [AGE] year-old male, on 11/19/21 with diagnoses includingparaplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), accidental discharge from unspecified firearms or gun, broken mandible (jaw), broken first rib and broken thoracic vertebra (the middle section of the spine), and generalized muscle weakness. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/26/21 and 2/26/22, indicated the resident was able to communicate, remember, comprehend, and make decisions. Resident 1 was incontinent (unable to voluntarily control) of bowel and bladder functions, was totally dependent on staff for transferring in and out of his bed, with toilet use, personal hygiene, dressing, and bathing/showering. Resident 1 was unable to walk and required a wheelchair for mobility. A review of Physician ' s Orders for Resident 1, dated 4/27/22, indicated the resident may go OOP with responsible party for personal business. The same day the order was discontinued. A review of Resident 1's Health Status Note, written by Licensed Vocational Nurse 9 (LVN 9), dated 4/27/22, indicated Resident 1 returned to facility (form OOP) asking for medication to be sent with him for AMA discharge. The physician (MD 3) was contacted to notify of resident's discharge AMA and to obtain authorization to give the resident his medications upon discharge. MD 3 gave the okay to discharge Resident 1 AMA with all remaining medication. Resident 1 was discharged AMA, via wheelchair, accompanied by family, and with all remaining medications. On 7/8/22, at 2:37 pm, during an interview with MD 2 and concurrent review of the Physician ' s Orders, MD 2 stated that originally Resident 1 had an order to go OOP to the DMV on 4/27/22 but the order was discontinued hours later the same day (4/27/22). MD 2 stated he did not personally give or discontinue Resident 1 ' s order to go OOP on 4/27/22 to the DMV. MD 2 stated a resident must have a physician's order to leave the facility, and he and the other physicians in his physician's group (MDs 1 and 3) give OOP orders or deny such orders if they think a resident would not be safe outside the facility. MD 2 stated MDs 1 and 3 suspected Resident 1 was doing drug-related activities and that was the reason the why they canceled Resident 1 ' s OOP order. MD 2 stated that to his knowledge, Resident 1 did not have a drug test confirming the suspected drug-related activities and did not have documented safety concerns for Resident 1 go OOP. MD 2 stated he did not give a discharge order, did not conduct a physician ' s discharge medical evaluation, did not do a medication reconciliation, did not complete a discharge summary, and did not provide a written 30-day discharge notice of impending discharge. MD 2 stated there was no immediate plan to discharge Resident 1. (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 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/22 at 10:40 am, during an interview, Resident 1 stated that on 4/27/22, he and a family friend (FF 1) went to the DMV and returned to the facility around 4 pm. After the staff assisted him with incontinent care, a staff told him he had to leave the facility immediately because he went to the DMV without permission from a physician. Resident 1 stated FF 1 wheeled him out at 5 pm. Resident 1 stated he felt messed up, it's like I knew I wasn't ready to leave the facility for good. They knew I had nowhere to go at the time, but they didn't care what was going to happen to me. Resident 1 stated Resident 2 offered him to stay at his place and FF 1 and another friend brought him to the apartment, located on a second floor. Thefriends were not able to put him in bed because the hospital bed in the apartment was too high. The friends left to go to work, and he stayed alone. Resident 1 stated he could not reach cups to serve water from the faucet to drink from because they were in high cabinets, and he had to drink from a faucet in the bathroom using his hand. Resident 1 stated his cellphone was broken and he could not call anybody for help, he was scared and helpless. There was no food or air conditioning in the apartment. Resident 1 said he had nothing to eat the evening of 4/27/22 and spent the entire night in his wheelchair soiled and wet. Resident 1 stated that Resident 2 informed Family Member 1 (FM 1) where he was. The following day, 4/28/22, at 1 pm, FM 1 and a friend came to rescue him. Resident 1 stated he was embarrassed, afraid, hungry, thirsty, in pain, and was traumatized. On 7/12/22, at 11:35 am, during an interview, Resident 2 (Resident 1 ' s roommate) stated that on 4/27/22, after the facility did not allow Resident 1 to return, he gave him permission to stay in his vacant apartment which had a hospital bed. Resident 2 stated that since he was unable to contact Resident 1 by phone, he called FM 1. On 7/12/22, at 3:30 pm, during an interview, Case Manager (CM) stated on 4/27/22 she became aware that Resident 1 had a physician ' s order to go OOP to the DMV, but prior to 4/27/22, MD 3 had told her that Resident 1 should not have any more orders to go OOP due to safety concerns and on 4/27/22, she called MD 3 to clarify Resident 1 ' s OOP order. MD 3 told her to cancel the order which she did and notified the ADM. CM stated she did not know what the safety concerns were. CM 1 stated she did not provide Resident 1 with a discharge assessment, a notice of discharge, or a discharge care plan. On 7/12/22, at 3:40 pm, during an interview, the ADM stated on 4/27/22, CM informed him that a physician had canceled Resident 1 ' s order to go OOP to the DMV due to safety concerns. On 7/12/22, at 4 pm, during an interview, the Director of Medical Records (DMR), after reviewing Resident 1 ' s medical record, stated the resident ' s record did not contain: a physician ' s documentation of the basis of discharge; a physician ' s discharge evaluation; a physician ' s discharge summary; a nurse ' s discharge assessment; a 30-day written notice of discharge; a nursing discharge care plan; a medication list provided to Resident 1 with the necessary education about the medications; and an inventory list of belongings and equipment Resident 1 took with him when he was discharged on [DATE] at 5 pm. (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 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/13/22, at 12:40 pm, during an interview, FM 1 stated the facility did not inform her they were discharging Resident 1 on 4/27/22. FM 1 learned the following day (4/28/2022) about the discharge of Resident 1 after she called the facility, and the nurse told her Resident 1 was gone and did not know where he went. FM 1 stated she felt upset and scared not knowing where Resident 1 was, and then Resident 2 called her and informed her Resident 1 was in his apartment. FM 1 stated she did not have a car and so she asked a friend of hers to go check on Resident 1. FM 1 stated the friend found Resident 1 in Resident 2 ' s apartment but Resident 1 could not get to the door because he had fallen and was crying. FM 1 stated the friend went to pick her up and both returned to Resident 2 ' s apartment where Resident 1 was on the floor, crying, wet with urine and soiled with feces. FM 1 crying stated she felt awful seeing Resident 1 soaking wet and with feces all over his back. FM 1 stated Resident 1 was too traumatized to go back to a facility. He (Resident 1) won ' t even go to a hospital because he thinks they'll make him go to another place like that (the facility) and he ' s (Resident 1) too scared. On 7/13/22, at 5 pm, during an interview, MD 1 stated residents require a physician's permission to leave the facility. MD 1 stated discharge AMA applied to residents leaving OOP without a physician's permission and was a justification for immediate discharge from the facility. MD 1 stated MD 2 ordered the facility to discharge Resident 1 AMA. MD 1 confirmed there was no planned discharge, physician ' s documentation of the basis for discharging Resident 1 and there was no discharge summary. On 7/15/22, at 12:30 pm, during an interview, the SSD stated the facility did not provide a safe discharge to Resident 1. On 7/15/22, at 1 pm, during an interview, SSD stated the facility did not ask Resident 1 to sign the form for Discharge AMA as per policy. SSD stated Resident 1 did not request to be discharged AMA. On 4/27/22, Resident 1 went to the DMV and when he returned to the facility staff told him he had to leave immediately. On 7/15/22, at 2:45 pm, during an interview, the ADM acknowledged the policy on Transfer and Discharge was not implemented when Resident 1 was discharged on [DATE]. On 7/15/22, at 3:10 pm, during an interview, the ADON stated Resident 1 ' s discharge was not planned or necessary based on the facility ' s policy on Transfer and Discharge. A review of the facility's policy titled, Transfer and Discharge, dated 6/1/21. The policy indicated, the facility will only transfer or discharge residents if: - The facility closes; - The resident fails to pay for their admission; - A physician determines and documents that the resident's needs cannot be met by the facility, - A physician determines and documents that the resident no longer needs the services of the facility; and - A physician determines and documents that the resident poses a threat to their own safety or the safety of others in the facility. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will provide and document the following discharge services: - A 30-day-written-notice of discharge; - A physician's evaluation of the resident ' s medical needs; - A physician ' s medication reconciliation; - A physician's discharge summary; - A nursing discharge assessment; - A nursing discharge nursing care plan; - A list of the resident ' s medications upon discharge; - Education regarding how a resident should take their medications; - A safe location to go the resident to go to; and - Arrange for another physician to take over the resident's care after they leave the facility. A review of the facility's policy titled, Discharge Against Medical Advice, dated 6/1/21, indicated the purpose of the policy was to respect the right of a resident or resident ' s representative to make informed decisions that are against medical advice and to inform them of the potential risks and consequences of their actions. If a resident desires to leave the facility against medical advice, a licensed nurse will ask the resident or the resident ' s representative to sign (the form) AD - 05 - Form A - Discharge Against Medical Advice . VIII. Nursing staff will document in the progress notes all pertinent information concerning the resident ' s actions, including the resident ' s stated reasons for his/her desire to leave the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. Building B. Wing	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40537 Based on interview and record review the facility failed provide one of five sampled (Resident 1) with a written notice of discharge at least 30 days in advance with the reason for the discharge, the effective date of discharge, the location to which the resident is discharged , and the information about the resident ' s appeal rights, as indicated in the facility ' s policy on Transfer and Discharge. On 4/27/22, around 5 pm, after returning to the facility from conducting personal business and without prior notice, Resident 1 was discharged against medical advice (AMA) because the resident left and the physician (MD 2) had cancelled (discontinued) the order given earlier the same day to go out on pass (OOP, being temporarily absent from the facility). As a result, Resident 1 spent the night alone at an empty apartment without food, air conditioning, and telephone to call for help, sitting in his wheelchair soaked in urine and feces (bowel movements or stool), and was found by a friend and Family Member 1 (FM 1) on the floor the following day (4/28/22) around 1 pm, crying, hungry, thirsty, soiled, scared, in pain, embarrassed, helpless, and was traumatized. On 7/15/22 at 12:06 pm, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) situation under 42CFR S483.15(c)(3) Notice before transfer. The Administrator (ADM), the Assistant Director of Nursing (ADON), and the Social Services Director (SSD) were notified of the IJ situation from the facility ' s failure to ensure Resident 1 was afforded a written notice of discharge at least 30 days in advance. On 7/16/22 at 12:00 pm, the IJ situation was removed in the presence of the ADM, while onsite, after verifying the implementation of the facility ' s submitted and accepted IJ Removal Plan. The IJ removal plan included the following summarized actions: 1. The facility attempted to contact Resident 1 and their representative to invite him to return to the facility or to assist Resident 1 with being admitted to another facility. 2. The SSD, ADM, and ADON reviewed all residents ' records with planned discharge/transfer to ensure compliance with regulatory requirements. 3. The SSD provided training to the ADM, the ADON, and three physicians on the facility ' s policies and procedures pertaining to discharging residents, resident rights, and resident neglect. 4. The facility created a discharge procedure checklist and discharge documentation auditing program to ensure all discharge planning is completed before a resident is discharged from the facility. 5. Training to all social services and nursing staff regarding the facility ' s discharge documentation auditing program, discharge procedures, resident rights, and resident neglect. (continued on next page)

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F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross-reference F600, F622, and F624. Findings: A review of Resident 1 ' s Admission Record (Face Sheet), dated 6/24/22, indicated the facility admitted Resident 1, a [AGE] year-old male, on 11/19/21 with diagnoses includingparaplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), accidental discharge from unspecified firearms or gun, broken mandible (jaw), broken first rib and broken thoracic vertebra (the middle section of the spine), and generalized muscle weakness. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/26/21 and 2/26/22, indicated the resident was able to communicate, remember, comprehend, and make decisions. Resident 1 was incontinent (unable to voluntarily control) of bowel and bladder functions, was totally dependent on staff for transferring in and out of his bed, with toilet use, personal hygiene, dressing, and bathing/showering. Resident 1 was unable to walk and required a wheelchair for mobility. A review of Physician ' s Orders for Resident 1, dated 4/27/22, indicated the resident may go OOP with responsible party for personal business. The same day the order was discontinued. A review of Resident 1's Health Status Note, written by Licensed Vocational Nurse 9 (LVN 9), dated 4/27/22, indicated Resident 1 returned to facility (from OOP) asking for medication to be sent with him for AMA discharge. The physician (MD 3) was contacted about Resident 1's discharge AMA and to obtain authorization to give the resident his medications upon discharge. MD 3 gave the okay to discharge Resident 1 AMA with all remaining medication. Resident 1 was discharged AMA, via wheelchair, accompanied by family, and with all remaining medications. On 7/8/22, at 2:37 pm, during an interview with MD 2 and concurrent review of the Physician ' s Orders, MD 2 stated that originally Resident 1 had an order to go OOP to the Department of Motor Vehicles (DMV) on 4/27/22 but the order was discontinued hours later the same day (4/27/22). MD 2 stated he did not personally give or discontinue Resident 1 ' s order to go OOP on 4/27/22 to the DMV. MD 2 stated a resident must have a physician's order to leave the facility, and he and the other physicians in his physician's group (MDs 1 and 3) give OOP order or do not give such order if they think a resident would not be safe outside the facility. MD 2 stated MDs 1 and 3 suspected Resident 1 was doing drug-related activities and that was the reason the why they canceled Resident 1 ' s OOP order. MD 2 stated that to his knowledge, Resident 1 did not have a drug test confirming the suspected drug-related activities and did not have documented safety concerns for Resident 1 go OOP. MD 2 stated he did not give a discharge order, did not conduct a physician ' s discharge medical evaluation, did not do a medication reconciliation, did not complete a discharge summary, and did not provide a written 30-day discharge notice of impending discharge. MD 2 stated there was no immediate plan to discharge Resident 1. (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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/22 at 10:40 am, during an interview, Resident 1 stated that on 4/27/22, he and a family friend (FF 1) went to the DMV and returned to the facility around 4 pm. After the staff assisted him with incontinent care, a staff told him he had to leave the facility immediately because he went to the DMV without permission from a physician. Resident 1 stated FF 1 wheeled him out at 5 pm. Resident 1 stated he felt messed up, it's like I knew I wasn't ready to leave the facility for good. They knew I had nowhere to go at the time, but they didn't care what was going to happen to me. Resident 1 stated Resident 2 offered him to stay at his place and FF 1 and another friend brought him to the apartment, located on a second floor. Thefriends were not able to put him in bed because the hospital bed in the apartment was too high. The friends left to go to work, and he stayed alone. Resident 1 stated he could not reach cups to serve water from the faucet to drink from because they were in high cabinets, and he had to drink from a faucet in the bathroom using his hand. Resident 1 stated his cellphone was broken and he could not call anybody for help, he was scared and helpless. There was no food or air conditioning in the apartment. Resident 1 said he had nothing to eat the evening of 4/27/22 and spent the entire night in his wheelchair soiled and wet. Resident 1 stated that on 4/28/22, Resident 2 informed Family Member 1 (FM 1) where he was. On 4/28/22, at 1 pm, FM 1 and a friend came to rescue him. Resident 1 stated he was embarrassed, afraid, hungry, thirsty, in pain, and was traumatized. On 7/12/22, at 11:35 am, during an interview, Resident 2 (Resident 1 ' s roommate) stated that on 4/27/22, after the facility did not allow Resident 1 to return, he gave him permission to stay in his vacant apartment which had a hospital bed. Resident 2 stated since he was unable to contact Resident 1 by phone, he called FM 1 and told her where Resident 1 was. On 7/12/22, at 3:30 pm, during an interview, Case Manager (CM) stated on 4/27/22 she became aware that Resident 1 had a physician ' s order to go OOP to the DMV, but prior to 4/27/22, MD 3 had told her that Resident 1 should not have any more orders to go OOP due to safety concerns and on 4/27/22, she called MD 3 to clarify Resident 1 ' s OOP order. MD 3 told her to cancel the order which she did and notified the ADM. CM stated she did not know what the safety concerns were. CM 1 stated she did not provide Resident 1 with a discharge assessment, a notice of discharge, or a discharge care plan. On 7/12/22, at 3:40 pm, during an interview, the ADM stated on 4/27/22, CM informed him that a physician had canceled Resident 1 ' s order to go OOP to the DMV due to safety concerns. On 7/12/22, at 4 pm, during an interview, the Director of Medical Records (DMR), after reviewing Resident 1 ' s medical record, stated the resident ' s record did not contain: a physician ' s documentation of the basis of discharge; a physician ' s discharge evaluation; a physician ' s discharge summary; a nurse ' s discharge assessment; a 30-day written notice of discharge; a nursing discharge care plan; a medication list provided to Resident 1 with the necessary education about the medications; and an inventory list of belongings and equipment Resident 1 took with him when he was discharged on [DATE] at 5 pm. (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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/13/22, at 12:40 pm, during an interview, FM 1 stated the facility did not inform her they were discharging Resident 1 on 4/27/22. FM 1 learned the following day (4/28/2022) about the discharge of Resident 1 after she called the facility, and the nurse told her Resident 1 was gone and did not know where he went. FM 1 stated she felt upset and scared not knowing where Resident 1 was, and then Resident 2 called her and informed her Resident 1 was in his apartment. FM 1 stated she did not have a car and so she asked a friend of hers to go check on Resident 1. FM 1 stated the friend found Resident 1 in Resident 2 ' s apartment but Resident 1 could not get to the door because he had fallen and was crying. FM 1 stated the friend went to pick her up and both returned to Resident 2 ' s apartment where Resident 1 was on the floor, crying, wet with urine and soiled with feces. FM 1 crying stated she felt awful seeing Resident 1 soaking wet and with feces all over his back. FM 1 stated Resident 1 was too traumatized to go back to a facility. He (Resident 1) won ' t even go to a hospital because he thinks they'll make him go to another place like that (the facility) and he ' s (Resident 1) too scared. On 7/13/22, at 5 pm, during an interview, MD 1 stated residents require a physician's permission to leave the facility. MD 1 stated discharge AMA applied to residents leaving OOP without a physician's permission and was a justification for immediate discharge from the facility. MD 1 stated MD 2 ordered the facility to discharge Resident 1 AMA. MD 1 confirmed there was no planned discharge, physician ' s documentation of the basis for discharging Resident 1 and there was no discharge summary. On 7/15/22, at 12:30 pm, during an interview, the SSD stated the facility did not provide a safe discharge to Resident 1. On 7/15/22, at 12:50 pm, during an interview, SSD stated the resident was not given a written notice of discharge at least 30 days in advance with the reason for discharge, the effective date and the appeals rights. SSD stated Resident 1 ' s discharge was not planned. On 7/15/22, at 1 pm, during an interview, SSD stated the facility did not ask Resident 1 to sign the form for Discharge AMA as per policy. SSD stated Resident 1 did not request to be discharged AMA. On 4/27/22, Resident 1 went to the DMV and when he returned to the facility staff told him he had to leave immediately. On 7/15/22, at 2:45 pm, during an interview, the ADM stated Resident 1 was not given a written notice of discharge 30 days prior to discharge on 4/27/22. On 7/15/22, at 3:10 pm, during an interview, the ADON stated Resident 1 ' s discharge was not planned, and a notice of discharge was not given to Resident 1 at least 30 days in advance. A review of the facility's policy titled, Transfer and Discharge, dated 6/1/21. The policy indicated the facility will provide a 30-day written notice of discharge.

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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	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40537 Based on interview and record review the facility failed to provide sufficient preparation to ensure a safe discharge for one of five sampled residents (Resident 1). On 4/27/22, around 5 pm, after returning to the facility from conducting personal business at the Department of Motor Vehicles (DMV) and without prior notice, preparation and orientation, Resident 1 was discharged against medical advice (AMA) because the resident left with a friend to the DMV and the physician (MD 2) had cancelled (discontinued) the order given earlier, on the same day, to go out on pass (OOP, being temporarily absent from the facility). Resident 1 did not have a place where to go and was not given time to make living arrangements. As a result, Resident 1 spent the night alone at an empty apartment without food, air conditioning, and telephone to call for help, sitting in his wheelchair soaked in urine and feces (bowel movements or stool), and was found by a friend and Family Member 1 (FM 1) on the floor the following day (4/28/22) around 1 pm, crying, hungry, thirsty, soiled, scared, in pain, embarrassed, helpless, and was traumatized. On 7/15/22 at 12:06 pm, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) situation under 42CFR S483.15(c)(7) Orientation for transfer or discharge. The Administrator (ADM), the Assistant Director of Nursing (ADON), and the Social Services Director (SSD) were notified of the IJ situation from the facility ' s failure to ensure Resident 1 was provided sufficient preparation and orientation to ensure safe and orderly discharge from the facility. On 7/16/22 at 12:00 pm, the IJ situation was removed in the presence of the ADM, while onsite, and after verifying the implementation of the facility ' s submitted and accepted IJ Removal Plan. The IJ removal plan included the following summarized actions: 1. The facility attempted to contact Resident 1 and their representative to invite him to return to the facility or to assist Resident 1 with being admitted to another facility. 2. The SSD, ADM, and ADON reviewed all residents ' records with planned discharge/transfer to ensure compliance with regulatory requirements. 3. The SSD provided training to the ADM, the ADON, and three physicians on the facility ' s policies and procedures pertaining to discharging residents, resident rights, and resident neglect. 4. The facility created a discharge procedure checklist and discharge documentation auditing program to ensure all discharge planning is completed before a resident is discharged from the facility. 5. Training to all social services and nursing staff regarding the facility ' s discharge documentation auditing program, discharge procedures, resident rights, and resident neglect. Cross-reference F600, F622, and F623. (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	Findings: A review of Resident 1 ' s Admission Record (Face Sheet), dated 6/24/22, indicated the facility admitted Resident 1, a [AGE] year-old male, on 11/19/21 with diagnoses including paraplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), accidental discharge from unspecified firearms or gun, broken mandible (jaw), broken first rib and broken thoracic vertebra (the middle section of the spine), and generalized muscle weakness. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/26/21 and 2/26/22, indicated the resident was able to communicate, remember, comprehend, and make decisions. Resident 1 was incontinent (unable to voluntarily control) of bowel and bladder functions, was totally dependent on staff for transferring in and out of his bed, with toilet use, personal hygiene, dressing, and bathing/showering. Resident 1 was unable to walk and required a wheelchair for mobility. A review of Physician ' s Orders for Resident 1, dated 4/27/22, indicated the resident may go OOP with responsible party for personal business. The same day the order was discontinued. A review of Resident 1's Health Status Note, written by Licensed Vocational Nurse 9 (LVN 9), dated 4/27/22, indicated Resident 1 returned to facility asking for medication to be sent with him for AMA discharge. The physician (MD 3) was contacted about Resident 1's discharge AMA and to obtain authorization to give the resident his medications upon discharge. MD 3 gave the okay to discharge Resident 1 AMA with all remaining medication. Resident 1 was discharged AMA, via wheelchair, accompanied by family, and with all remaining medications. On 7/8/22, at 2:37 pm, during an interview with MD 2 and concurrent review of the Physician ' s Orders, MD 2 stated that originally Resident 1 had an order to go OOP to the DMV on 4/27/22 but the order was discontinued hours later the same day (4/27/22). MD 2 stated he did not personally give or discontinue Resident 1 ' s order to go OOP on 4/27/22 to the DMV. MD 2 stated a resident must have a physician's order to leave the facility, and he and the other physicians in his physician's group (MDs 1 and 3) give OOP order or do not give such orders if they think a resident would not be safe outside the facility. MD 2 stated MDs 1 and 3 suspected Resident 1 was doing drug-related activities and that was the reason the why they canceled Resident 1 ' s OOP order. MD 2 stated that to his knowledge, Resident 1 did not have a drug test confirming the suspected drug-related activities and did not have documented safety concerns for Resident 1 go OOP. MD 2 stated he did not give a discharge order, did not conduct a physician ' s discharge medical evaluation, did not do a medication reconciliation, did not complete a discharge summary, and did not provide a written 30-day discharge notice of impending discharge. MD 2 stated there was no immediate plan to discharge Resident 1. (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	On 7/12/22 at 10:40 am, during an interview, Resident 1 stated that on 4/27/22, he and a family friend (FF 1) went to the DMV and returned to the facility around 4 pm. After the staff assisted him with incontinent care, a staff told him he had to leave the facility immediately because he went to the DMV without permission from a physician. Resident 1 stated FF 1 wheeled him out at 5 pm. Resident 1 stated he felt messed up, it's like I knew I wasn't ready to leave the facility for good. They knew I had nowhere to go at the time, but they didn't care what was going to happen to me. Resident 1 stated Resident 2 offered him to stay at his place and FF 1 and another friend brought him to the apartment, located on a second floor. The friends were not able to put him in bed because the hospital bed in the apartment was too high. The friends left to go to work, and he stayed alone. Resident 1 stated he could not reach cups to serve water from the faucet to drink from because they were in high cabinets, and he had to drink from a faucet in the bathroom using his hand. Resident 1 stated his cellphone was broken and he could not call anybody for help, he was scared and helpless. There was no food or air conditioning in the apartment. Resident 1 said he had nothing to eat the evening of 4/27/22 and spent the entire night in his wheelchair soiled and wet. Resident 1 stated that the following day, 4/28/22, Resident 2 informed Family Member 1 (FM 1) where he was. On 4/28/22 at 1 pm, FM 1 and a friend came to rescue him. Resident 1 stated he was embarrassed, afraid, hungry, thirsty, in pain, and was traumatized. On 7/12/22, at 11:35 am, during an interview, Resident 2 (Resident 1 ' s roommate) stated that on 4/27/22, after the facility did not allow Resident 1 to return, he gave him permission to stay in his vacant apartment which had a hospital bed. On 7/12/22, at 3:30 pm, during an interview, Case Manager (CM) stated on 4/27/22 she became aware that Resident 1 had a physician ' s order to go OOP to the DMV, but prior to 4/27/22, MD 3 had told her that Resident 1 should not have any more orders to go OOP due to safety concerns and on 4/27/22, she called MD 3 to clarify Resident 1 ' s OOP order. MD 3 told her to cancel the order which she did and notified the ADM. CM stated she did not know what the safety concerns were. CM 1 stated she did not provide Resident 1 with a discharge assessment, a notice of discharge, or a discharge care plan. On 7/12/22, at 3:40 pm, during an interview, the ADM stated on 4/27/22, CM informed him that a physician had canceled Resident 1 ' s order to go OOP to the DMV due to safety concerns. On 7/12/22, at 4 pm, during an interview, the Director of Medical Records (DMR), after reviewing Resident 1 ' s medical record, stated the resident ' s record did not contain: a physician ' s documentation of the basis of discharge; a physician ' s discharge evaluation; a physician ' s discharge summary; a nurse ' s discharge assessment; a 30-day written notice of discharge; a nursing discharge care plan; a medication list provided to Resident 1 with the necessary education about the medications; and an inventory list of belongings and equipment Resident 1 took with him when he was discharged on [DATE] at 5 pm. (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	On 7/13/22, at 12:40 pm, during an interview, FM 1 stated the facility did not inform her they were discharging Resident 1 on 4/27/22. FM 1 learned the following day (4/28/2022) about the discharge of Resident 1 after she called the facility, and the nurse told her Resident 1 was gone and did not know where he went. FM 1 stated she felt upset and scared not knowing where Resident 1 was, and then Resident 2 called her and informed her Resident 1 was in his apartment. FM 1 stated she did not have a car and so she asked a friend of hers to go check on Resident 1. FM 1 stated the friend found Resident 1 in Resident 2 ' s apartment but Resident 1 could not get to the door because he had fallen and was crying. FM 1 stated the friend went to pick her up and both returned to Resident 2 ' s apartment where Resident 1 was on the floor, crying, wet with urine and soiled with feces. FM 1 crying stated she felt awful seeing Resident 1 soaking wet and with feces all over his back. FM 1 stated Resident 1 was too traumatized to go back to a facility. He (Resident 1) won ' t even go to a hospital because he thinks they'll make him go to another place like that (the facility) and he ' s (Resident 1) too scared. On 7/13/22, at 5 pm, during an interview, MD 1 stated residents require a physician's permission to leave the facility. MD 1 stated discharge AMA applied to residents leaving OOP without a physician's permission and was a justification for immediate discharge from the facility. MD 1 stated MD 2 ordered the facility to discharge Resident 1 AMA. MD 1 confirmed there was no planned discharge, physician ' s documentation of the basis for discharging Resident 1 and there was no discharge summary. On 7/15/22, at 12:30 pm, during an interview, the SSD stated the facility did not provide a safe discharge to Resident 1. On 7/15/22, at 1 pm, during an interview, SSD stated the facility did not ask Resident 1 to sign the form for Discharge AMA as per policy. SSD stated Resident 1 did not request to be discharged AMA. On 4/27/22, Resident 1 went to the DMV and when he returned to the facility staff told him he had to leave immediately. On 7/15/22, at 2:45 pm, during an interview, the ADM acknowledged the policy on Transfer and Discharge was not implemented when Resident 1 was discharged on [DATE]. On 7/15/22, at 3:10 pm, during an interview, the ADON stated Resident 1 ' s discharge was not planned or necessary based on the facility ' s policy on Transfer and Discharge. A review of the facility's policy titled, Transfer and Discharge, dated 6/1/21. The policy indicated, the facility will only transfer or discharge residents if: - The facility closes; - The resident fails to pay for their admission; - A physician determines and documents that the resident's needs cannot be met by the facility, - A physician determines and documents that the resident no longer needs the services of the facility; and - A physician determines and documents that the resident poses a threat to their own safety or the safety of others in the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will provide and document the following discharge services: - A 30-day-written-notice of discharge; - A physician's evaluation of the resident ' s medical needs; - A physician ' s medication reconciliation; - A physician's discharge summary; - A nursing discharge assessment; - A nursing discharge nursing care plan; - A list of the resident ' s medications upon discharge; - Education regarding how a resident should take their medications; - A safe location to go the resident to go to; and - Arrange for another physician to take over the resident's care after they leave the facility. A review of the facility's policy titled, Discharge Against Medical Advice, dated 6/1/21, indicated the purpose of the policy was to respect the right of a resident or resident ' s representative to make informed decisions that are against medical advice and to inform them of the potential risks and consequences of their actions. If a resident desires to leave the facility against medical advice, a licensed nurse will ask the resident or the resident ' s representative to sign (the form) AD - 05 - Form A - Discharge Against Medical Advice . VIII. Nursing staff will document in the progress notes all pertinent information concerning the resident ' s actions, including the resident ' s stated reasons for his/her desire to leave the facility.