Printed: 02/22/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 43830 10th Street West Lancaster, CA 93534	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN Based on interview and record review who was unable to walk, was incort was dependent on staff for activitie bathing, and personal hygiene), was providers to provide goods and ser anguish, or emotional distress). Or personal business at the Department Resident 1 was discharged against and the physician (MD 2) had canced pass (OOP, being temporarily abservables (OOP, being temporarily abservables (OOP, being temporarily abservables). As a result, Resident 1 spent the notelephone to call for help, sitting in was found by a friend and Family Norying, hungry, thirsty, soiled, scard On 7/15/22 at 12:06 pm, the State which the facility's non-compliance cause, serious injury, harm, impair from Abuse, Neglect, and Exploited and the Social Services Director (Sesident 1 was free from neglect. On 7/16/22 at 12:00 pm, the IJ situ verifying the implementation of the	ight alone at an empty apartment without his wheelchair soaked in urine and fee Member 1 (FM 1) on the floor the followed, embarrassed, in pain, helpless, and Survey Agency (SSA) identified an Immit with one or more requirements of partment, or death of a resident) situation to the floor. The Administrator (ADM), the Ass (SSD) were notified of the IJ situation from the floor was removed in the presence of facility 's submitted and accepted IJ Floor to the floor summarized actions: Resident 1 and their representative to	ONFIDENTIALITY** 40537 five sampled residents (Resident 1), bowel and bladder functions, and obility, transfers, dressing, toilet use, acility, its employees or service to avoid physical harm, pain, mental to the facility from conducting ut prior notice and preparation, esident left with a friend to the DMV urlier the same day to go out on out food, air conditioning, and ses (bowel movements or stool), and aring day (4/28/22) around 1 pm, do was traumatized. In mediate Jeopardy (IJ-a situation in icipation has caused, or is likely to under 42CFR S483.12 Freedom istant Director of Nursing (ADON), om the facility 's failure to ensure the ADM, while onsite, after temoval Plan.

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
The Ellison John Transitional Care		43830 10th Street West Lancaster, CA 93534	FCODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	The SSD, ADM, and ADON reviewed all residents ' records with planned discharge/transfer to ensure compliance with regulatory requirements. 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.		
Residents Affected - Few		procedure checklist and discharge documpleted before a resident is discharged	
	Training to all social services an program, discharge procedures, re	d nursing staff regarding the facility 's o	discharge documentation auditing
	Cross-reference F622, F623, and F	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.		
		r Resident 1, dated 4/27/22, indicated the ness. The same day the order was disc	
	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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			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 43830 10th Street West	P CODE
The Ellison John Transitional Care	Center	Lancaster, CA 93534	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2 stated that originally Resident 1 h discontinued hours later the same Resident 1 's order to go OOP on to leave the facility, and he and the or deny such order if they think a re suspected Resident 1 was doing dhe Resident 1 's OOP order. MD 2 states the suspected drug-related activities MD 2 stated he did not give a discharge Resident 1. On 7/12/22 at 10:40 am, during an went to the DMV and returned to the staff told him he had to leave the factories what was going to happen to and another friend brought him to thim in bed because the hospital be stayed alone. Resident 1 stated he because they were in high cabinets Resident 1 stated his cellphone was helpless. There was no food or air evening of 4/27/22 and spent the e Resident 2 informed Family Membra friend came to rescue him. Resident and the facility did not allow Resident 1. On 7/12/22, at 11:35 am, during an after the facility did not allow Resident 1. On 7/12/22, at 3:30 pm, during an after the facility Resident 1 is oOP ADM. CM stated she did not know 1 with a discharge assessment, a resident 2 in the did not know 1 with a discharge assessment, a resident 1 should not have any mode MD 3 to clarify Resident 1 is OOP ADM. CM stated she did not know 1 with a discharge assessment, a resident 1 should pm, during an incomplete the same season.	terview with MD 2 and concurrent reviendad an order to go OOP to the DMV on day (4/27/22). MD 2 stated he did not put/27/22 to the DMV. MD 2 stated a resion other physicians in his physician's grossident would not be safe outside the farug-related activities and that was the related that to his knowledge, Resident 1 is and did not have documented safety harge order. MD 2 stated there was no interview, Resident 1 stated that on 4/2 he facility around 4 pm. After the staff a scility immediately because he went to exheeled him out at 5 pm. Resident 1 stated that nowher me. Resident 1 stated Resident 2 offers he apartment, located on a second flood in the apartment was too high. The frould not reach cups to serve water from the partment of the partment. Resident 1 is broken and he could not call anybody conditioning in the apartment. Residentie night in his wheelchair soiled and er 1 (FM 1) where he was. The following ent 1 stated he was embarrassed, afrain interview, Resident 2 (Resident 1 's refer to go OOP to the DMV, but prior to 4/2 ore orders to go OOP due to safety conditioner. MD 3 told her to cancel the order what the safety concerns were. CM 1 shorter is good of the DMV, but prior to 4/2 order. MD 3 told her to cancel the order what the safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were. CM 1 shorter is good of the DMV due to safety concerns were.	a/27/22 but the order was bersonally give or discontinue ident must have a physician's order up (MDs 1 and 3) give OOP order acility. MD 2 stated MDs 1 and 3 eason the why they canceled did not have a drug test confirming concerns for Resident 1 go OOP. immediate plan to discharge 27/22, he and a family friend (FF 1) esisted him with incontinent care, a the DMV without permission from a lated he felt messed up, it's like I are to go at the time, but they didn't end him to stay at his place and FF 1 or. Thefriends were not able to put fiends left to go to work, and he form the faucet to drink from the bathroom using his hand. In a for the property of the was scared and to 1 said he had nothing to eat the wet. Resident 1 stated that g day, 4/28/22, at 1 pm, FM 1 and id, hungry, thirsty, in pain, and to stay in his vacant apartment at Resident 1 by phone, he called the stated she did not provide Resident end and notified the stated she did not provide

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Facility ID: 555904

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			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZI 43830 10th Street West	P CODE
		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 DEFIC (Each deficiency must be preceded by	EIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharging Resident 1 on 4/27/22. Resident 1 after she called the facil he went. FM 1 stated she felt upset called her and informed her Reside asked a friend of hers to go check apartment but Resident 1 could not friend went to pick her up and both crying, wet with urine and soiled wi and with feces all over his back. FM (Resident 1) won 't even go to a ho (the facility) and he 's (Resident 1) On 7/13/22, at 5 pm, during an inte facility. MD 1 stated discharge AM/was a justification for immediate dis On 7/15/22, at 12:30 pm, during an Resident 1. On 7/15/22, at 1 pm, during an inte Discharge AMA as per policy. SSD Resident 1 went to the DMV and w On 7/15/22, at 2:50 pm, during an in Discharge AMA, the ADM stated R Advice for him to sign. A review of the facility 's policy title Purpose to establish, operationalizensure . the prevention . of . neglect Policy I. Each resident abuse and neglect potential resident abuse and neglect.	interview, FM 1 stated the facility did r FM 1 learned the following day (4/28/2 ity, and the nurse told her Resident 1 v and scared not knowing where Resident 1 was in his apartment. FM 1 stated on Resident 1. FM 1 stated the friend for get to the door because he had fallen returned to Resident 2 's apartment with feces. FM 1 crying stated she felt aw M 1 stated Resident 1 was too traumatizespital because he thinks they'll make it too scared. Tryiew, MD 1 stated residents require a papplied to residents leaving OOP with scharge from the facility. MD 1 stated M interview, the SSD stated the facility did not as stated Resident 1 did not request to be then he returned to the facility staff told interview with the ADM and concurrent the esident 1 was not provided with the Ford, Abuse Prevention and Prohibition P et and maintain an Abuse Prevention a cit, mistreatment in accordance with feat to be free from mistreatment, neglect to enable the identification of the follow cit: f. inadequate provision of care g. C. g someone unattended who needs supplements.	2022) about the discharge of was gone and did not know where ent 1 was, and then Resident 2 she did not have a car and so she bund Resident 1 in Resident 2 's and was crying. FM 1 stated the here Resident 1 was on the floor, will seeing Resident 1 soaking wet zed to go back to a facility. He nim go to another place like that physician's permission to leave the nout a physician's permission and MD 2 ordered the discharge AMA. id not provide a safe discharge to sk Resident 1 to sign the form for e discharged AMA. On 4/27/22, him he had to leave immediately. review of the facility 's policy on rm A - Discharge Against Medical rogram, dated 6/1/21, indicated, nd Prohibition Program designed to deral and state requirements . V. Identification A. The Facility ring signs and symptoms of aregiver indifference to resident 's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
The Ellison John Transitional Care		43830 10th Street West Lancaster, CA 93534	. 3352	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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** 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 an 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.			
		ation was removed in the presence of t facility 's submitted and accepted IJ R		
	The IJ removal plan included the fo	ollowing summarized actions:		
	The facility attempted to contact to assist Resident 1 with being adn	Resident 1 and their representative to nitted to another facility.	invite him to return to the facility or	
	The SSD, ADM, and ADON revier compliance with regulatory required	ewed all residents ' records with planne ments.	ed discharge/transfer to ensure	
	The SSD provided training to the ADM, the ADON, and three physicians on the facility 's policies a procedures pertaining to discharging residents, resident rights, and resident neglect.			
		procedure checklist and discharge documpleted before a resident is discharged		
	Training to all social services and program, discharge procedures, re	d nursing staff regarding the facility 's os sident rights, and resident neglect.	discharge documentation auditing	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		A. Building	07/16/2022		
	555904	B. Wing	01/10/2022		
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P 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 con	tact 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 informati	on)		
F 0622	Cross-reference F600, F623, and F	F624.			
Level of Harm - Immediate	Findings:				
jeopardy to resident health or safety		on Record (Face Sheet), dated 6/24/22			
Residents Affected - Few		on 11/19/21 with diagnoses includingr spically caused by spinal injury or dise			
	(a disorder in which a person has o	ifficulty recovering after experiencing of ied firearms or gun, broken mandible (j	or witnessing a terrifying event),		
		on of the spine), and generalized muscl			
		Data Set (MDS, a standardized assess			
		ted the resident was able to communic continent (unable to voluntarily control)			
		ransferring in and out of his bed, with to Resident 1 was unable to walk and requ			
		Resident 1, dated 4/27/22, indicated t ness. The same day the order was disc			
		atus Note, written by Licensed Vocation			
	discharge. The physician (MD 3) w	cility (form OOP) asking for medication as contacted to notify of resident's disc	harge AMA and to obtain		
		s medications upon discharge. MD 3 g n. Resident 1 was discharged AMA, vi			
	family, and with all remaining medic	cations.			
		terview with MD 2 and concurrent revieus			
	discontinued hours later the same	day (4/27/22). MD 2 stated he did not p	personally give or discontinue		
		4/27/22 to the DMV. MD 2 stated a res other physicians in his physician's gro	. ,		
	or deny such orders if they think a	resident would not be safe outside the rug-related activities and that was the r	facility. MD 2 stated MDs 1 and 3		
	Resident 1 's OOP order. MD 2 sta	ated that to his knowledge, Resident 1	did not have a drug test confirming		
		s and did not have documented safety arge order, did not conduct a physicial			
		on, did not complete a discharge sumn ng discharge. MD 2 stated there was r			
	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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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
The Ellison John Transitional Care		43830 10th Street West Lancaster, CA 93534	. 6052
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 7/12/22 at 10:40 am, during an went to the DMV and returned to the staff told him he had to leave the far physician. Resident 1 stated FF 1 knew I wasn't ready to leave the far care what was going to happen to and another friend brought him to thim in bed because the hospital be stayed alone. Resident 1 stated he because they were in high cabinets Resident 1 stated his cellphone was helpless. There was no food or air evening of 4/27/22 and spent the eresident 2 informed Family Membra friend came to rescue him. Resident aumatized. On 7/12/22, at 11:35 am, during an after the facility did not allow Resident and hospital bed. Resident called FM 1. On 7/12/22, at 3:30 pm, during an in Resident 1 should not have any modern material to the state of t	interview, Resident 1 stated that on 4/2 are facility around 4 pm. After the staff a citity immediately because he went to a wheeled him out at 5 pm. Resident 1 statility for good. They knew I had nowher me. Resident 1 stated Resident 2 offers he apartment, located on a second flood in the apartment was too high. The frould not reach cups to serve water from a faucet in the street of the partment. Resident and he could not call anybody conditioning in the apartment. Resident and the partment in this wheelchair soiled and the fact of the fac	27/22, he and a family friend (FF 1) ssisted him with incontinent care, a the DMV without permission from a atted he felt messed up, it's like I are to go at the time, but they didn't ed him to stay at his place and FF 1 or. Thefriends were not able to put riends left to go to work, and he form the faucet to drink from the bathroom using his hand. If you help, he was scared and to 1 said he had nothing to eat the wet. Resident 1 stated that g day, 4/28/22, at 1 pm, FM 1 and id, hungry, thirsty, in pain, and was becommate) stated that on 4/27/22, in to stay in his vacant apartment contact Resident 1 by phone, he with the did and notified the stated she did not provide Resident 1 plan. CM informed him that a physician nocerns. (DMR), after reviewing Resident 1 in 's documentation of the basis of summary; a nurse 's discharge re plan; a medication list provided in inventory list of belongings and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZI 43830 10th Street West Lancaster, CA 93534	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	G SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharging Resident 1 on 4/27/22. Resident 1 after she called the faci he went. FM 1 stated she felt upse called her and informed her Reside asked a friend of hers to go check apartment but Resident 1 could no friend went to pick her up and both crying, wet with urine and soiled wi and with feces all over his back. FM (Resident 1) won ' t even go to a he (the facility) and he 's (Resident 1) On 7/13/22, at 5 pm, during an inte facility. MD 1 stated discharge AM/ was a justification for immediate discharge Resident 1 AMA. MD 1 of the basis for discharging Resident On 7/15/22, at 12:30 pm, during an Resident 1. On 7/15/22, at 1 pm, during an inte Discharge AMA as per policy. SSD Resident 1 went to the DMV and won 7/15/22, at 2:45 pm, during an invas not implemented when Reside On 7/15/22, at 3:10 pm, during an ecessary based on the facility 's plant and the facility 's plant and the facility closes; A review of the facility's policy titled will only transfer or discharge resident. The facility closes; The resident fails to pay for their and the facility closes; A physician determines and documents.	A applied to residents leaving OOP with scharge from the facility. MD 1 stated Nonfirmed there was no planned discharge and there was no discharge summar an interview, the SSD stated the facility of stated Resident 1 did not request to be then he returned to the facility staff told interview, the ADM acknowledged the part 1 was discharged on [DATE]. Interview, the ADON stated Resident 1 policy on Transfer and Discharge, dated 6/1/2 ents if:	2022) about the discharge of was gone and did not know where ent 1 was, and then Resident 2 she did not have a car and so she bund Resident 1 in Resident 2 's and was crying. FM 1 stated the there Resident 1 was on the floor, wful seeing Resident 1 soaking wet zed to go back to a facility. He nim go to another place like that physician's permission to leave the nout a physician's permission and MD 2 ordered the facility to rge, physician 's documentation of your did not provide a safe discharge to like the had to leave immediately. See Resident 1 to sign the form for the discharged AMA. On 4/27/22, him he had to leave immediately. Poolicy on Transfer and Discharge 's discharge was not planned or I. The policy indicated, the facility be met by the facility, s the services of the facility; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE EIIISON JOHN TRANSILIONAL CARE	Center	43830 10th Street West Lancaster, CA 93534	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0622	The facility will provide and docume	ent the following discharge services:	
Level of Harm - Immediate jeopardy to resident health or	- A 30-day-written-notice of dischar	ge;	
safety	- A physician's evaluation of the res	sident 's medical needs;	
Residents Affected - Few	- A physician 's medication reconc	iliation;	
	- A physician's discharge summary		
	- A nursing discharge assessment;		
	- A nursing discharge nursing care		
	- A list of the resident 's medication		
	- Education regarding how a reside		
	- A safe location to go the resident		
	- 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. It 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.		

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZI 43830 10th Street West Lancaster, CA 93534	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely notification to the rebefore transfer or discharge, include **NOTE- TERMS IN BRACKETS IN Based on interview and record reviwritten notice of discharge at least discharge, the location to which the rights, as indicated in the facility 's returning to the facility from conduct discharged against medical advice (discontinued) the order given earlist the facility). As a result, Resident 1 spent the notelephone to call for help, sitting in was found by a friend and Family Morying, hungry, thirsty, soiled, scare on 7/15/22 at 12:06 pm, the State which the facility's non-compliance cause, serious injury, harm, impairs before transfer. The Administrator Director (SSD) were notified of the written notice of discharge at least on 7/16/22 at 12:00 pm, the IJ situ verifying the implementation of the The IJ removal plan included the formula of the situation of the serious Resident 1 with being admitted assist Resident 1 with being admitted to assist Resident 1 with being admitted to a situation of the procedures pertaining to discharge ensure all discharge planning is contact and discharge planning is contac	sident, and if applicable to the resident ing appeal rights. IAVE BEEN EDITED TO PROTECT Composition of the service of the se	representative and ombudsman, ONFIDENTIALITY** 40537 e sampled (Resident 1) with a the discharge, the effective date of nation about the resident 's appeal 4/27/22, around 5 pm, after or notice, Resident 1 was he physician (MD 2) had cancelled DP, being temporarily absent from out food, air conditioning, and es (bowel movements or stool), and ring day (4/28/22) around 1 pm, d was traumatized. mediate Jeopardy (IJ-a situation in ricipation has caused, or is likely to under 42CFR S483.15(c)(3) Notice g (ADON), and the Social Services to ensure Resident 1 was afforded a the ADM, while onsite, after temoval Plan. invite him to return to the facility or and discharge/transfer to ensure as on the facility 's policies and ent neglect. umentation auditing program to d from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022	
NAME OF PROVIDED OF CURRUES		STREET ADDRESS, CITY, STATE, ZI	D CODE	
The Ellison John Transitional Care	NAME OF PROVIDER OR SUPPLIER The Ellison, John Transitional Care Center		PCODE	
		Lancaster, CA 93534		
For information on the nursing home's	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 0623	Cross-reference F600, F622, and F	-624.		
Level of Harm - Immediate jeopardy to resident health or	Findings:			
safety		on Record (Face Sheet), dated 6/24/22		
Residents Affected - Few	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 disorde (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.			
		r Resident 1, dated 4/27/22, indicated the ness. The same day the order was disc		
	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
The Ellison John Transitional Care		43830 10th Street West	FCODE
The Linear Committee of the Committee of		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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/22 at 10:40 am, during an went to the DMV and returned to th staff told him he had to leave the far physician. Resident 1 stated FF 1 knew I wasn't ready to leave the far care what was going to happen to rand another friend brought him to thim in bed because the hospital be stayed alone. Resident 1 stated he because they were in high cabinets Resident 1 stated his cellphone was helpless. There was no food or air evening of 4/27/22 and spent the e 4/28/22, Resident 2 informed Famil friend came to rescue him. Resident traumatized. On 7/12/22, at 11:35 am, during an after the facility did not allow Resid which had a hospital bed. Resident FM 1 and told her where Resident On 7/12/22, at 3:30 pm, during an in Resident 1 should not have any moderate may be a stated the stated she did not know 1 with a discharge assessment, a resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated she did not know 1 with a discharge assessment, a resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 with a discharge assessment, a resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated the resident 1 should not have any moderate may be a stated his particular.	interview, Resident 1 stated that on 4/2 he facility around 4 pm. After the staff a scility immediately because he went to a wheeled him out at 5 pm. Resident 1 st cility for good. They knew I had nowher me. Resident 1 stated Resident 2 offers he apartment, located on a second flood in the apartment was too high. The frecould not reach cups to serve water frest, and he had to drink from a faucet in the stroken and he could not call anybody conditioning in the apartment. Resident (PM 1) where he was. On that 1 stated he was embarrassed, afraid a interview, Resident 2 (Resident 1 the return, he gave him permissions 2 stated since he was unable to contains.	27/22, he and a family friend (FF 1) ssisted him with incontinent care, a the DMV without permission from a atted he felt messed up, it's like I re to go at the time, but they didn't ed him to stay at his place and FF 1 or. Thefriends were not able to put riends left to go to work, and he form the faucet to drink from the bathroom using his hand. If you have to he had nothing to eat the wet. Resident 1 stated that on 4/28/22, at 1 pm, FM 1 and a hungry, thirsty, in pain, and was becommate) stated that on 4/27/22, in to stay in his vacant apartment ct Resident 1 by phone, he called the which she did and notified the stated she did not provide Resident 1 plan. CM informed him that a physician nocerns. (DMR), after reviewing Resident 1 in summary; a nurse is discharge the plan; a medication list provided in inventory list of belongings and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	IP CODE
The Ellison John Transitional Care Center		43830 10th Street West	P CODE
John Handidonal Sale Johns		Lancaster, CA 93534	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharging Resident 1 on 4/27/22. Resident 1 after she called the facil he went. FM 1 stated she felt upset called her and informed her Reside asked a friend of hers to go check apartment but Resident 1 could not friend went to pick her up and both crying, wet with urine and soiled wi and with feces all over his back. FM (Resident 1) won 't even go to a ho (the facility) and he 's (Resident 1) On 7/13/22, at 5 pm, during an inte facility. MD 1 stated discharge AM/ was a justification for immediate dis discharge Resident 1 AMA. MD 1 of the basis for discharging Resident On 7/15/22, at 12:30 pm, during an Resident 1. On 7/15/22, at 12:50 pm, during an discharge at least 30 days in advar rights. SSD stated Resident 1 's di On 7/15/22, at 1 pm, during an inte Discharge AMA as per policy. SSD Resident 1 went to the DMV and w On 7/15/22, at 2:45 pm, during an i discharge 30 days prior to discharge on 7/15/22, at 3:10 pm, during an i a notice of discharge was not giver	rview, MD 1 stated residents require a A applied to residents leaving OOP with scharge from the facility. MD 1 stated Nonfirmed there was no planned dischart 1 and there was no discharge summar 1 interview, the SSD stated the facility of a interview, SSD stated the resident was not planned. Tryiew, SSD stated the facility did not as stated Resident 1 did not request to be hen he returned to the facility staff told interview, the ADM stated Resident 1 was not planned. The on 4/27/22. The review, the ADON stated Resident 1 was not planned and the returned to the facility staff told interview, the ADON stated Resident 1 was not planned.	2022) about the discharge of was gone and did not know where ent 1 was, and then Resident 2 If she did not have a car and so she ound Resident 1 in Resident 2 If she did not have a car and so she ound Resident 1 in Resident 2 If she did not have a car and so she ound Resident 1 in Resident 2 If she did not have a car and so she ound Resident 1 was on the floor, which seeing Resident 1 soaking wet zed to go back to a facility. He him go to another place like that In physician's permission to leave the hout a physician's permission and who 2 ordered the facility to large, physician If she documentation of your did not provide a safe discharge to the short given a written notice of effective date and the appeals Sek Resident 1 to sign the form for the discharged AMA. On 4/27/22, him he had to leave immediately. It is discharge was not planned, and ance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	555904	A. Building B. Wing	07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 43830 10th Street West Lancaster, CA 93534	
For information on the nursing home's pla	an to correct this deficiency, please conf	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0624	Prepare residents for a safe transfer or discharge from the nursing home.		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Each deficiency must be preceded by full regulatory or LSC identifying information)		

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 con	tact 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	Findings:		
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 discharge AMA, via wheelchair, accompanied by family, and with all remaining medication. Resident 1 was discharge 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		

Printed: 02/22/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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 con	tact 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	s plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES		

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 555904

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 43830 10th Street West Lancaster, CA 93534	
For information on the nursing home's	plan to correct this deficiency, please con	·	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	s plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2022
NAME OF PROVIDER OR SUPPLIER The Ellipon John Transitional Care Conter		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 con	tact 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	The facility will provide and document the following discharge services:		
Level of Harm - Immediate	- A 30-day-written-notice of dischar	ge;	
jeopardy to resident health or safety	- A physician's evaluation of the res	sident 's medical needs;	
Residents Affected - Few	- A physician 's medication reconc	iliation;	
	- 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.		