STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055698	A. BUILDING _____ B. WING _____	11/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	**8060 FROST STREET SAN DIEGO, CA 92123**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 94 sampled residents (Resident A), who was unable to care for self, unable to walk, unable to provide food for herself, unable to toilet self, and unable to obtain necessary medications for her illnesses, was safely discharged to an appropriate care setting. In addition, the facility failed to provide goods and services to ensure a safe and appropriate discharge. As a result, Resident A was physically unable to care for self, was discharged to her trailer without a physician being notified, was discharged with a urinary catheter in place, and without means to care for herself. Resident A did not have a phone to call for help in case of an emergency, was unable to get out of bed on her own, unable to walk, unable to use the toilet, was a diabetic without medications or means to test her blood sugars, was a diabetic that had not eaten since lunch time, had no food in her trailer, and had no medications for her pain, and other critical medications that were required. Resident A laid in her bed at her home for hours before the police arrived. Resident A was found dirty and without necessary care/equipment to sustain life. In addition, as a result, any of the 93 residents in the facility could be discharged before the facility ensured goods and services were arranged for a safe and appropriate discharge. Findings: Resident A was first admitted to a local acute care facility on 4/12/14, after she was found in her home unable to care for herself. Resident A was discharged from the local acute care facility on 4/15/14, with [DIAGNOSES REDACTED]. kidney), and dehydration, per the acute care facility's discharge summary. Also, Resident A had medical history [DIAGNOSES REDACTED]. Resident A was admitted to this facility on 4/15/14, with [DIAGNOSES REDACTED]. sheet. Resident A was admitted with her companion of 4 years, a small dog. On 9/29/14, the department received two complaints, alleging that Resident A was discharged from the facility, to her home and was unable to care for herself. On 10/7/14 at 11:55 A.M., Resident A's clinical record was reviewed. According to the MDS dated [DATE], Resident A was unable to ambulate, required extensive assistance with bed mobility, transfers, eating, toilet use and personal hygiene. Resident A required total dependency for dressing and locomotion. Resident A also had physical limitations to both of her arms and legs. Resident A's BIMS was 12 (score range of 00 being completely impaired to 15 no impairment mentally.) According to the CNA Daily Charting Form dated 8/1/14 through 9/8/14, Resident A required bed baths performed by the staff. The CNAs also documented Resident A had not ambulated and did not get out of bed. Resident A's pain level was documented every shift on the Medication Administration Record. According to Resident A's Pain Assessment Flow sheet, dated 9/6/14 through 9/9/14, the resident received pain medication three times per day. The pain medication administered to Resident A was [MEDICATION NAME] 5/325 mg (milligrams), 2 tablets. A physician's orders [REDACTED]. According to Resident A's Glucose/Insulin Record, dated 9/1/14 through 9/9/14, Resident A required finger sticks for blood sugar monitoring three times a day before meals. The results of the finger stick monitors dictated the amount of extra insulin Resident A required. Resident A required 1 extra unit of insulin before breakfast on 5 out of 9 days, 1-3 units of extra insulin on 2 out of 9 days before lunch and 1 extra unit of insulin on 5 out of 9 days before dinner. In addition, Resident A received, [MEDICATION NAME] 300 mg one capsule every night at bedtime for nerve pain; [MEDICATION NAME] 10 mg every 8 hours for 14 days (to end 9/13/14) for itchiness; [MEDICATION NAME] 20 mg everyday for high blood pressure; Aspirin 81 mg everyday for stroke prevention; [MEDICATION NAME] 40 mg every morning for swelling; [MEDICATION NAME] (potassium) 20 mEq (milliequivalents) every morning; Lorstantin 20 mg every morning for [MEDICAL CONDITION] for high cholesterol; [MEDICATION NAME] 50 mg 2 tablets every morning for high blood pressure; and [MEDICATION NAME] 30 mg subcutaneous injections every 12 hours for prevention of blood clots. Resident A was also ordered,[MEDICATION NAME] 0.4 mg one tablet under the tongue three times as needed for chest pain and to notify the physician if no pain relief; [MEDICATION NAME] 0.5 mg one tablet by mouth three times a day as needed for muscle spasms; [MEDICATION NAME] 5/325 mg two tablets every 6 hours as needed for moderate pain; and, [MEDICATION NAME] cream 1% to rash on right side of trunk twice a day and [MEDICATION NAME] cream 1% to rash on right side of upper thigh twice a day. Nursing documentation dated, 10/26/14 (incorrect date documented due to Resident discharged [DATE]), of Resident A's fall risk assessment scored resident as being a high risk for falls. The Licensed Nurse Weekly Summary, dated 9/8/14, Resident A's pain level ranged from 7 to 8 on a 0 (no pain) to 10 (extreme pain) pain scale. In addition, Resident A had a 3 pound weight loss over the prior 3 weeks. Resident A with chronic back rash. The Occupational Therapy certification period of 8/16/14 through 9/12/14, read, Patient is gravely debilitated. Patient complains of pain in varying spots, similar to [MEDICAL CONDITION] symptoms. Patient is unable to stand or perform ADL tasks secondary to lack of insight of her deficits. Patient is unmotivated to learn or care for herself and wants others to do the care . During the same Occupation Therapy Certification period, a functional skills assessment was performed. Resident A needed supervision for self feeding, maximum assist with hygiene and grooming, total assistance with bathing, maximum assist with dressing, and total dependence with bed mobility. Resident A's care plan, dated 8/18/14 was reviewed. A care plan was initiated [MEDICAL CONDITION] (methicillan resistant staph aureus: bacterial infection resistant to most antibiotics) to back, UTI (urinary tract infection), CAD [MEDICAL CONDITION] [MEDICAL CONDITION] bladder (loss of urinary control) with indwelling catheter (tube going into the bladder that is connected to a bag for urine to drain into), [MEDICAL CONDITION] (painful nerves in extremities), muscle spasms, and pet therapy (her dog.) Per the discharge plan dated 8/23/14, To discharge to appropriate placement. and resident's estimated length of stay is 4-5 weeks. According to the nursing note dated 9/9/14 at 3:30 P.M., .Stated she wanted to leave due to her dog not being able to accompany her in her room due to his barking. Visibly upset throughout the day due to dog not being in her room . Resident A was discharged on [DATE]. There was no physician's discharge order and no physician note in the clinical record. There was no discharge instructions in the clinical record. There was no documentation of prescription or medication education provided to the resident regarding the critical need for the medications. Resident A signed an AMA (Against

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055698	A. BUILDING _____ B. WING _____	11/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	8060 FROST STREET SAN DIEGO, CA 92123

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) Medical Advice) form. According to the facility's policy dated 5/1/12, Discharge Against Medical Advice, Mitigating circumstances influencing the resident's decision to leave should be evaluated and addressed in an effort to prevent the resident from leaving against medical advice. A licensed nurse will notify the attending physician, on call physician, or medical director of the resident's desire to leave AMA. Documentation of nursing or physician's evaluation and addressing the reason Resident A signed out AMA could not be located in the clinical record. Complainant 1 was interviewed via telephone on 10/7/14 at 5:15 P.M. Complainant 1 stated that as soon as the department's survey team walked into the facility on [DATE], to conduct the annual recertification survey, the Administrator of the facility instructed her to take Resident A's dog outside and to keep the dog outside. Complainant 1 said that on that day, it was extremely hot and after 5 hours she and the dog needed water. She said she called into the facility to ask if she could go inside to retrieve her purse and water. She was told not to enter the facility and that someone would bring her purse and water. Complainant 1 further said the Administrator of the facility asked her to take the dog home. She said she informed the administrator she would not and the administrator instructed her to ask another employee. Complainant 1 added, she was unaware of complaints about the dog and said the dog did not bark. Complainant 1 further shared, SW 1 told her a cab was coming for Resident A and that the cab would pull around to the back of the facility and that they would sneak Resident A and her belonging into it. Complainant 1 stated SW 1 instructed two CNAs to pick Resident A up from her wheelchair and place her into the cab. Complainant 1 said she was concerned for Resident A's welfare. She further said, Resident A wanted to go home because she could not have her dog with her. Complainant 1 said Resident A could not do things for herself and she was totally dependent on staff. Resident A was interviewed in person on 10/10/14 at 12:15 P.M., at her new long term care facility. Resident A was observed in her bed, in a hospital gown, and had limited mobility. Resident A attempted to pick up the phone receiver in an attempt to answer and had difficulty in picking up the receiver due to deformity of her hands. Resident A said she was angry at the previous long term care facility because they would not allow her to keep her dog. Resident A stated, Skylark (dog) doesn't bark. I had him there for 4 1/2 months and all of a sudden, I can't have the dog, so I was out of there! Resident A further said, she left AMA only because she was told that day that she could not have her dog. Resident A stated, All of a sudden I was discharged AMA. Resident A said she would have stayed if they would have continued to allow her to keep her dog. Resident A also said the facility lied about her dog barking, stated it was the first time she had heard about it on that day (9/9/14). Resident A also stated, it was because the department was in the building conducting the survey. Resident A also said she did think about what she was going to do or how she was going to make it, but was tired and fell a sleep. Resident A said she called the taxi herself and had to crawl inside of her trailer. Resident A said the facility did not provide her any discharge instructions regarding her medical condition (pain, diabetes care, indwelling catheter care), medication prescriptions (insulin for diabetes, pain medications, or [MEDICATION NAME] for chest pain), or arrange for any assistance in her home. On 10/10/14 at 2:55 P.M., RN 1 was interviewed. RN 1 confirmed she was the nurse that discharged Resident A. RN 1 stated she did not speak to a physician and did not obtain a discharge order. RN 1 stated she only took care of the paperwork. RN 1 confirmed that she did not discuss care of the indwelling catheter, medications, or follow up with Resident A. She further said her understanding was, if a resident discharged AMA, the nurse was not responsible to go over medications, follow up or any discharge issues with them. On 10/10/14 at 3:40 P.M., CNA 1 was interviewed. CNA 1 said he was working a different hallway and was called to the back side of the facility to assist Resident A into a taxi. CNA 1 said it was very unusual for the taxi to pick up residents in the back and not the front of the facility. He further said, It did feel sneaky, real sneaky. CNA 1 said after they transferred Resident A from her wheel chair into the taxi, he and CNA 2 rode in the Social Worker's car and followed the taxi to the resident's home. CNA 1 said the resident was not capable of caring for herself and was very concerned for her safety. CNA 1 stated,It was not right and I kept saying it was not right. CNA 1 said the Social Worker told him not to worry and assured CNA 1 someone would check on Resident A. He further stated, She could die, we even talked about it and was told not to worry (reassured by the Social Worker). CNA 1 described Resident A's living situation as poor. CNA 1 said they left Resident A in her bed. CNA 1 stated they left water beside her and there was no food. CNA 1 confirmed Resident A was unable to walk or to care for herself. CNA 1 said Resident A had her dog until 9/9/14. He further stated he believed the dog was taken away due to the recertification survey of the facility. CNA 1 stated, I think the dog was her family and I think once they said the dog had to leave, she wanted to go. On 10/14/14 at 3:10 P.M., CNA 2 was interviewed. CNA 2 said he was asked by the Administrator to assist Resident A into the taxi. CNA 2 said the situation did not feel right because Resident A was a maximum assist. CNA 2 said after Resident A was in the taxi, he rode with the Social Worker and another CNA to Resident A's home. CNA 2 said the trailer was in a mess and that he kept saying it was not right. CNA 2 said the Social Worker told him it would be ok and she would call an agency to check on the resident. CNA 2 said he had not heard there was an issue with the dog until 9/9/14. CNA 2 further said he thought it became an issue due to the recertification survey. He further said once Resident A was told she could not have the dog, she was too mad and would not consider staying. CNA 2 also said he could not believe the facility administration would allow her to leave since she could not care for herself. CNA 2 said the discharge occurred around 3:30 P.M. and Resident A had not eaten since lunch. CNA 2 also confirmed there was no food in Resident A's home. On 10/14/14 at 3:40 P.M., the Administrator was interviewed. The Administrator said she did not know much about the case. She said she remembered Resident A left AMA and they were concerned the Resident's daughter would not check on the resident. The Administrator believed SW 1 called Adult Protective Services. The Administrator said the AIT (Administrator In Training) took care of the issues with Resident A, and she was not involved because she was busy with the survey. The Administrator said she heard once there was a complaint about the dog barking. She said she was unaware that the dog had been in the facility for 4 1/2 months. The Administrator further stated 9/9/14, was the first day she heard there was an issue. The Administrator said she did not believe Resident A left because of the dog. The Administrator continued to deny knowing anything about the AMA and the Resident's living situation. The Administrator said the AIT had communication problems and he had not informed her of the issue with the resident and the dog. On 10/20/14 at 10:10 A.M., AIT was interviewed. AIT said he was informed of Resident A's discharge when she was, in the action of leaving, physically leaving. AIT further said he did not tell anyone to discharge the resident and he did not tell anyone to take the dog outside and to stay outside. On 10/14/14 at 5:15 P.M., SW 1 was interviewed. SW 1 said the AIT told her the Administrator said to keep the dog outside. SW 1 said she had not received complaints regarding issues with the dog until 9/9/14. SW 1 said there were no discharge plans in place for Resident A to be safely discharged . SW 1 also stated the AIT came and told her to discharge the resident. SW 1 said the AIT had been in Resident A's room alone and then came and told her to discharge the resident. SW 1 said she went into the residents room but the resident was too angry and was not open to any further discussion. SW 1 further said, Resident A called her own taxi. SW 1 stated she informed the Administrator of the situation on that day (9/9/14). SW 1 said CNA 1 and CNA 2 rode in her car with her to the Resident's home. SW 1 said the trailer was a mess and she started heaving because of the filth. SW 1 said there was no food in the trailer and that Resident A could not cook even if there were food items. SW 1 acknowledged Resident A as being totally dependent on others for her care and meal preparations. She further stated, the dog was not the issue and she felt that it was because the surveyors were at the facility. SW 1 confirmed the discharge was inappropriate. SW 1 confirmed she called Adult Protective Services once she returned to the facility because she knew the resident could not walk, go to the restroom, and do anything for herself. SW 1 also stated Resident A did not have the medications she needed and was unable to survive without assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055698	A. BUILDING _____ B. WING _____	**11/13/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIREMONT HEALTHCARE & WELLNESS CENTRE, LLC	**8060 FROST STREET SAN DIEGO, CA 92123**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) Resident A's primary physician at the facility did not respond for an interview. On 10/16/14 at 1:18 P.M., the NP stated he was notified of Resident A's discharge after the resident left the facility. According to the facility's undated policy, Discharge and Transfer of Residents, To ensure that discharge planning is complete and appropriate and that necessary information is communicated to the continuing care provider The Attending Physician will review the resident's progress and determine a possible discharge date .The Attending Physician will provide an order for [REDACTED]. Resident A discharged from the facility on 9/9/14 at 3:30 P.M., and was left unattended at her residence. A neighbor called local law enforcement which arrived at Resident A's home at 7 P.M., and placed Resident A on a legal hold for grave disability at 9:45 P.M. Resident A was transported to a local emergency room and after a 6 day stay was admitted to a different skilled nursing facility. According to the police report dated 9/9/14, Resident A was found, unable to to open the door, laying on her bed in a very dirty trailer from front to back. Resident A also had a catheter in place and it appeared full. Resident A was not able to sit up in her bed not able to test her blood sugar levels as required twice a day, unable to get to the refrigerator without assistance is not able to get up to drink water or get food Resident A is also required to wear adult diapers, however she is unable to change them herself. According to the acute care facility's admission history and physical, dated 9/10/14, Resident A's [DIAGNOSES REDACTED]. Resident A also presented to the emergency room with two pressure ulcers (unstageable, on heel and toe), urinary indwelling catheter bag that was full and the tubing was clogged, and Resident A had a strong smell of urine and feces. On 10/15/14 at 2:15 P.M., an Immediate Jeopardy was called related to Neglect; based on the facility not providing services and goods to meet the needs of Resident A who was discharged . The facility did not assess Resident A's mental capacity to ensure a safe discharge. Resident A, who was not able to provide care for herself, was left by facility staff in her trailer, without food. In addition, the facility did not assess for safety, had no physician involvement or physician order [REDACTED]. Resident A was transferred from a taxi to her bed and left in her home, alone. Police arrived hours later and placed Resident A on a legal hold due to grave disability. Resident A required admission to an acute care facility for grave disability within hours of her discharge from the facility.