

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>056144</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/20/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>HUNTINGTON PARK NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>6425 MILES AVENUE HUNTINGTON PARK, CA 90255</b>	
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 0660  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Plan the resident's discharge to meet the resident's goals and needs.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its undated policy and procedures (P/P) for Discharge, to ensure medications were given to one of three sampled residents (Resident 1) upon discharge from the facility. This deficient practice resulted in three (3) [MEDICATION NAME] (anti-anxiety) one milligram (mg) pills, [MEDICATION NAME](sedative) 10 mg pills, and 59 [MEDICATION NAME] (pain killer) 10-325 mg pills missing before the resident was discharged from the facility. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the resident was admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening, dated [DATE], indicated the resident was able to make her needs known and was able to understand other. The MDS indicated Resident 1 required extensive assist of a two-person physical assist for activities of daily living ((ADL) toilet use, personal hygiene, eating). A review of the Progress Notes dated 12/26/19 and timed at 1:55 p.m. documented a physician order [REDACTED]. A review of a Late Entry Progress Note dated [DATE] and timed at 10:57 p.m., documented on 12/26/19 at 10 p.m. discharge paperwork and medications administration teaching were given to Resident 1 and witnessed by Resident 1's Responsible Party 1 (RP 1). The Progress Note documented the facility's staff gave report to the on-coming shift at 11 p.m. of Resident 1 being on possession signed discharged paperwork, all medications, and waiting for transportation. A review of Resident 1's Situation Background Assessment Re-evaluation ((SBAR) communication document) dated 12/27/19 and timed at 10 a.m., indicated Resident 1's RP 2 informed the licensed nurses of Resident 1's medication bubble packs being empty. The SBAR indicated Resident 1 assessed and identified no changes in level of consciousness. The SBAR indicated Resident 1's physician was notified of the incident and gave orders to transfer Resident 1 to the general acute care hospital (GACH) for further evaluation. On 1/2/2020 at 3:44 p.m. during an interview, the Director of Nursing (DON) stated upon Resident 1's discharge, the facility's licensed nurses gave the resident the Ambien, [MEDICATION NAME] and [MEDICATION NAME] for when discharge. The DON stated since the discharge did not occur on 12/26/19, the licensed staff failed to remove the medications from Resident 1's bedside. On 1/3/2020 at 7:56 a.m. during an interview, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was not discharged on [DATE] due to the lack of transportation. LVN 1 stated all medications were given to Resident 1 on 12/26/19 because she was to be discharge that same day. On 1/3/2020 at 8:10 a.m., during an interview, LVN 2 stated on 12/27/19 at approximately 7:30 a.m., she saw the bubble packs of medications in Resident 1's night stand and the were empty. A review of the undated policy and procedure (P/P) titled Discharge/Transfer of the Resident, indicated the purpose of the facility was to provide safe departure when leaving from the facility. The P/P indicated a release of medication form was to be given to the resident when medications were being discharge home and a list of medications with instructions to be given.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.