2nd POC accepted 10/10/19 @ 2:50pm 36526

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING _____ B. WING _____	R-C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CARE CENTER	2000 W WASHINGTON BL LOS ANGELES, CA 90018

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{F 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the First Revisit of a complaint investigation during an Abbreviated Standard Survey. Complaint number: CA00641635 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 36526 The inspection was limited to the specific First Revisit and does not represent the findings of a full inspection of the facility. Three deficiencies were issued for the First Revisit survey for complaint CA00641635.	{F 000}	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	
{F 660} SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	{F 660}	F 660 **Immediate Corrective Action** On 09/13/19, Interdisciplinary team (social service designee, MDS nurse, director of nursing and administrator) discussed with resident 2 regarding his discharge planning. Resident 2 expressed his preference discharge plan and location to be at a Board and Care at this meeting, please see attached IDT dated 09/13/19. On 09/13/19, resident 2 physician came and assessed resident 2, H&P attached.	10/07/19

RECEIVED OCT 07 2019 By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/07/19

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.

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{F 660}	Continued From page 1 updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent	{F 660}	On 09/17/19, psychologist came and assessed resident in regards to placement to lower level of care/Board and care, please see attached psychology progress note. Clarification of discharge order/Telephone order dated on "08/23/19" @ 2:32 P.M corrected by licensed, noted on "08/28/19", see attached TO order and licensed note. Resident 2 currently resides at Sunnyview Convalescent Center, pending discharge for psychiatrist clearance. **Identification of other areas/residents** Administrator and social services designee reviewed five current resident's discharge plan to ensure facility is in compliance on discharge planning No other areas were affected.	10/07/19

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{F 660}	Continued From page 2 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its plan of correction (POC) dated 8/23/19, by not implementing a discharge plan that included a post-discharge plan of care, ensuring participation of the resident and/or the resident's family on discharge planning, and documenting in the progress notes the physician assessment and discharge planning for one of three sampled residents (Resident 2). These deficient practices resulted in Resident 2's rights being violated by not acknowledging Resident 2' wishes to participate in the discharge planning. Findings: A review of Resident 2's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on 7/5/19, and last readmitted on 8/23/19. Resident 2's diagnoses	{F 660}	**Measure to prevent recurrence** On 10/02/19, in-service provided by administrator interdisciplinary team such as social service designee, MDS nurse, rehab, dietary supervisor, director of nursing and business office regarding discharge plan: 1. To be initiated upon admission and regular re-evaluation/follow up with involvement of interdisciplinary team, and resident/representative to ensure resident's discharge needs identified and assisted prior discharge to preferred location. 2. Physician visit/assessment and progress note to be included on resident's discharge plan. 3. Post discharge plan including referral to local agency to be arranged and documented.	10/07/19

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{F 660}	Continued From page 3 included schizoaffective (chronic mental condition characterized by hallucinations and mood disorder) disorder, generalized weakness, and tuberculosis ([TB] potentially serious infectious bacterial disease that mainly affects the lungs). A review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care screening, dated 7/12/19, indicated the resident was able to make his needs known and able to make his self understood. The MDS indicated Resident 2 required of one-person physical assist for activities of daily living ([ADL] self-care activities performed daily such as grooming, dressing, and bathing). The MDS indicated there was no discharge plan initiated for Resident 2. A review of Resident 2's Baseline Care Plan, revised on 8/27/19, indicated that Resident 2 had an uncertain discharge plan and the outcome was to provide three months of ancillary (wide range of healthcare services provided) services and treatment for tuberculosis disease. The staff goals included to initiate discharge planning process, and for Resident 2 to have a safe and appropriate placement. A review of the unsigned physician's telephone order, dated 8/23/19 and timed at 2:32 p.m., indicated to discharge Resident 2 to an independent living facility. A review of Resident 2's Self Administration of Drugs Assessment, dated 8/23/19, indicated that the Interdisciplinary Team's ([IDT] a group of disciplines that work together towards a common goal for a resident) determined that Resident 2 was not safe to self-administer medications due to his schizophrenia diagnosis.	{F 660}	**Monitoring performance integration into quality assurance system** Administrator and social service designee will review residents' chart weekly to reinsure compliance regarding discharge plan. Finding will be corrected as needed and will be reviewed by QA committee monthly times six months if further action is needed.	10/07/19

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{F 660}	Continued From page 4 A review of Resident 2's re-admitting physician's orders, dated 8/23/19 and timed at 8:20 p.m., indicated that Resident 2 was taking three different medications to treat his diagnosis of latent (carrier) tuberculosis. A review of Resident 2's psychotherapeutic (treatment for mental disorders) medication assessment, dated 8/23/19, indicated that Resident 2's inability to process his internal stimuli affected his activities of daily living (ADL) performance. A review of Resident 2's care plan titled, "ADL/Self Care Deficit," dated 8/26/19, indicated that Resident 2 required assistance with ADL's due to his weakness, poor balance, poor safety awareness, poor coordination and requiring extensive assist with ADL's. The goal indicated that Resident 2 would not decline. The staff interventions included to assist Resident 2 with toileting, grooming, turning, repositioning, assistive devices, and rehabilitation of physical/occupational therapy quarterly and as needed. A review of the IDT note titled, "Resident's Discharge Planning," dated 8/26/19, indicated that Resident 2 did not participate in the discharge planning. The IDT note indicated that the Social Services Designee (SSD) initiated the process of discharge and contacted Resident 2's previous assistive living facility. On 9/12/19 at 7:30 a.m., during an interview, Resident 2 stated, "I don't want to go back to that dirt hole." Resident 2 stated that he was not asked where he wanted to be discharged to.	{F 660}		

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{F 660}	Continued From page 5 Resident 2 stated that SSD came to his room and told him he was leaving soon and to get ready, that even if he did not have a home, he would be discharged. On 9/12/19 at 7:40 a.m., during a concurrent interview and record review of Resident 2's medical chart, the SSD stated that Resident 2's discharge order was obtained prior to Resident 2's re-admission to the facility. The SSD stated that Resident 2 did not participate in his discharge planning and that she was not aware that the resident did not want to leave the facility. The SSD stated that Resident 2's discharge plan was not appropriate. On 9/12/19 at 8:20 a.m., during an interview, Certified Nurse Assistant 1 (CNA 1) stated that Resident 2 required assistance with his ADL's and that Resident 2 had difficulty walking at times. On 9/12/19 at 10:08 a.m., during a concurrent interview and record review, the SSD was unable to find the nurses notes and assessments regarding Resident 2's discharge. A review of the facility's undated policy titled, "Transfer and Discharge Policy & Procedure," indicated that the transfer and discharge is ideally a planned event. The policy indicated the facility staff should handle the transfer/discharge of the residents' in a way that minimizes the resident's and family's anxiety (feeling of unease or worry).	{F 660}		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 6 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's staff failed to follow a resident's care plan and provide supervision for two of three sample residents (Resident 3 and 4). Resident 3 had a history of eloping (to leave unnoticed) from the facility. Resident 4 was recently admitted to the facility for suicidal ideation (thoughts of killing oneself) and attempts of walking into incoming traffic. These deficient practices resulted in Resident 3 leaving out on pass (OOP) and not returning to the facility, and Resident 4 eloping from the facility into the surrounding neighborhood unsupervised, creating the potential for physical and mental harm after not returning to the facility. Findings: a. A review of Resident 3's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on 7/5/19, and last readmitted on 8/23/19. Resident 3's diagnoses included anxiety (feeling of worry, nervousness, or unease), cocaine (strong addictive stimulant drug frequently used as a recreational drug) abuse, and altered mental status (disruption in how the brain works that causes a change in	F 689	F 689 **Immediate corrective action** Upon notification, resident 3 chart reviewed by administrator and director of nursing. Resident 3 has a capacity to understand and make decisions, see attached H&P dated on 07/27/19 and psychology assessment note dated on 09/03/19. Elopement assessment for resident 3 scored 6 out of 8, not at risk of elopement; resident 3 is capable of protecting herself. Resident has an out on pass order, noted on 09/06/19, see attached OOP order. 09/09/19 @ 11:30 am., resident signed out on pass form and left, see attached OOP form. Resident did not return back to facility within 72 hours; and physician notified and discharged against medical advice, see attached policy, AMA discharge order and licensed note.	10/07/19

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F 689	Continued From page 7 behavior). A review of Resident 3's Minimum Data Set (MDS), a standardized assessment and care screening, dated 8/2/19, indicated the resident was able to make her needs known and able to make her self-understood. The MDS indicated Resident 3 required of one-person physical limited assist for activities of daily living ([ADL] self-care activities performed daily such as dressing, grooming, and bathing). A review of Resident 3's Baseline Care Plan, revised on 8/27/19, indicated that Resident 3 had an uncertain discharge plan and the outcome was to provide three months of ancillary (wide range of healthcare services provided) services and treatment for tuberculosis ([TB] potentially serious infectious bacterial disease that mainly affects the lungs) disease. The staff goals included to initiate discharge planning process, and for Resident 3 to have a safe and appropriate placement. A review of the unsigned physician's telephone order, dated 9/6/19 and timed at 9 a.m., indicated that Resident 3 was able to go on Out on Pass (OOP) for four (4) hours and as needed. A review of the facility's document titled, "Release of Responsibility for Leave of Absence," indicated that Resident 3 signed the OOP log on 9/4/19 at 11:30 a.m., and on 9/9/19 at 11:30 a.m. A review of the Multidisciplinary Team Notes indicated the following: 1. On 8/30/19 at 3:05 p.m., Resident 3 left the facility against medical advice (AMA).	F 689	A courtesy phone call made to resident's 3 friend. Friend stated "not to worry" and resident 3 is fine, see licensed note dated 09/13/19. Administrator in-serviced director of nursing and social services designee on 10/01/19 regarding adequate assessment, supervision and documentation on monitoring residents with suicidal upon admission and facility policy for suicidal residents, see attached policy. Director of nursing in-serviced licensed nurses 10/01/19 regarding the above and policy of suicidal residents.	10/07/19

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F 689	Continued From page 8 2. On 9/4/19 at 11:40 a.m., staff called Resident 3's physician to request an OOP order for the resident. 3. On 9/6/19 at 9 a.m., a clarification of the OOP order indicated that Resident 3 can go on OOP for four hours and as needed. At 12:20 p.m., Resident 3 leaves the facility on OOP. 4. On 9/9/19 at 11:30 a.m., Resident 3 leaves the facility for OOP and does not return. A review of Resident 3's Elopement Risk Assessment, dated 9/5/19, did not indicate the elopement that Resident 3 had on 8/30/19. On 9/12/19 at 10:34 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) stated that she was not aware that Resident 3 had left against medical advice on 8/30/19. LVN 1 stated that after the first incident Resident 3 should not have been given OOP orders. 1 b. A review of Resident 4's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on 8/22/19. Resident 4's diagnoses included suicidal ideation, paranoid schizophrenia (disease in which the mind does not agree with reality), and anxiety. A review of the facility's document titled, "New Admit Inquiry Record," dated 8/22/19, indicated that Resident 4 was being transferred to the nursing home with an admitting diagnosis of suicidal ideation, and history of in-and-out of homes/homeless. A review of Resident 4's care plan titled, "At Risk	F 689	**Identification of other residents** Eleven of charts with risk of elopement reviewed to ensure residents with risk of elopement received adequate supervision and assistance device. No other residents affected. Two recent admissions residents' charts with suicidal ideation reviewed and findings corrected immediately. **Measure to prevent reoccurrence** In-service given to licensed nurses and department heads on 10/01/19 by administrator and director of nursing regarding adequate supervision to residents with high risk of elopement. Elopement's assessment will be reviewed by director of nursing to ensure accuracy.	10/07/19

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F 689	Continued From page 9 for Harming self," dated 8/23/19, indicated that the goal was to assist Resident 4 to cope with thoughts of harming self. The staff interventions included to provide one-on-one supervision as indicated/needed and a safe environment. A review of Resident 4's care plan titled, "Elopement Risk," dated 8/23/19, indicated that the goal was for Resident 4 not to leave the facility without asking for permission. The staff interventions included to follow protocol for visual checks, and notify the physician of changes in condition. A review of Resident 4's Multidisciplinary Progress Record, indicated late entry for 8/24/19 at 6:30 a.m., indicated Resident 4 was seen leaving the facility and getting on a public transportation bus. The progress note indicated that facility staff attempted to convince Resident 4 to return to the facility, but was unsuccessful. On 9/12/19 at 10:08 a.m., during a concurrent interview and record review, the Social Services Designee (SSD) stated that since Resident 3 and 4 left the facility, they were no longer considered the facility's responsibility. On 9/12/19 at 10:50 a.m., during a concurrent interview and record review, LVN 1 stated that she was not aware that Resident 4 had suicidal ideation or that she had a care plan to be supervised. LVN 1 stated that staff did not follow Resident 4's care plan to be supervised. On 9/12/19 at 11:50 a.m., during a concurrent interview and record review, in the presence of the Director of Nurses (DON), SSD, and Medical Records (MR), the Administrator (ADM) stated	F 689	In-serviced social services designee and director of nursing on 10/01/19 regarding following facility policy on suicidal resident such as monitoring sign and symptom; visiting resident with suicidal ideation by social services and participation of social services, activities, family and contacting psychiatrist and physician immediately if symptom noted. **Monitoring performance** Discharge and admission charts will be reviewed weekly and as needed by administrator, director of nursing and social services designee for thirty days to ensure compliance. Finding will be corrected as needed and reported to QA committee if further action is needed.	10/07/19

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F 689	Continued From page 10 that once a resident leaves and does do not return its considered a discharged resident. The ADM stated that they are no longer responsible for Resident 3 and 4. The ADM stated she was not being aware that Resident 4 had suicidal ideation. The DON stated that the facility did not have a supervision policy.	F 689		
{F 711} SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician's visits with a written summary were completed and documented in the resident's clinical chart for two of three sampled residents (Resident 2 and 3). This deficient practice resulted in Resident 2's inadequate care planning for discharge, and Resident 3 not being seen initially by the primary physician to adequately care plan for her suicide	{F 711}	F 711 **Immediate corrective action** On September 19, administrator in-serviced medical director and 2 of UR physicians regarding policy of physician visit and letter of notification regarding physician visits were given to quality assurance doctors and mailed to doctors that have residents in the facility, see attached letter. **Identification of other residents** Ten recent admission charts reviewed to ensure facility is incompliance. No other areas identified.	10/07/19

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{F 711}	Continued From page 11 (killing oneself) prevention. Findings: a. A review of Resident 2's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on 7/5/19, and last readmitted on 8/23/19. Resident 1's diagnoses included schizoaffective (chronic mental condition characterized by hallucinations and mood disorder) disorder, generalized weakness, and tuberculosis ([TB] potentially serious infectious bacterial disease that mainly affects the lungs). A review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care screening, dated 7/12/19, indicated the resident was able to make his needs known and able to make his self understood. The MDS indicated Resident 2 required of one-person physical assist for activities of daily living ([ADL] self-care activities performed daily such as dressing, grooming, and bathing). The MDS indicated there was no discharge plan initiated for Resident 2. A review of Resident 2's Baseline Care Plan, revised on 8/27/19, indicated that Resident 2 had an uncertain discharge plan and the outcome was to provide three months of ancillary (wide range of healthcare services provided) services and treatment for his tuberculosis diagnosis. The staff goals included to initiate discharge planning process, and for Resident 2 to have a safe and appropriate placement. A review of the unsigned physician's telephone order, dated 8/23/19 and timed at 2:32 p.m., indicated to discharge Resident 2 to an	{F 711}	**Measure to prevent reoccurrence** Administrator in-serviced medical record supervisor on 10/04/19 regarding a physician visit within 72 hours of resident admission to complete a history and physical examination if the history and physical received upon admission was not completed by attending physician 5 days prior to admission and policy of physician visit, policy attached. **Monitoring performance** Medical record supervisor/designee will audit admission within 72 hours of admission to ensure compliance and finding will be addressed immediately by medical director/administrator, and reported monthly times 90 days if further action needed.	10/07/19

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	555071	A. BUILDING _____ B. WING _____	R-C 09/12/2019

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{F 711}	Continued From page 12 independent living facility. A review of the dated an Interdisciplinary Team ([IDT] group of disciplines working together towards a common goal for a resident) note titled, "Resident's Discharge Planning," 8/26/19, indicated that Resident 2 did not participate in the discharge planning. The IDT note indicated that the Social Services Designee (SSD) initiated the process of discharge and contacted Resident 2's previous assistive living facility. On 9/12/19 at 7:30 a.m., during an interview, Resident 2 stated, "I don't want to go back to that dirt hole." Resident 2 stated that he was not asked where he wanted to be discharged to. Resident 2 stated that SSD came to his room and told him he was leaving soon and to get ready, and that even if he did not have a home, he would be discharged. The SSD stated and confirmed that Resident 2 did not have a physician History and Physical (H/P) completed and a visit from the physician documented in the resident's medical chart. On 9/12/19 at 7:40 a.m., during a concurrent interview and record review of Resident 2's medical chart, the SSD stated that Resident 2's discharge order was obtained prior to Resident 2's re-admission to the facility. The SSD stated that Resident 2 did not participate in his discharge planning and that she was not aware that the resident did not want to leave the facility. The SSD stated that Resident 2's discharge plan was not appropriate. b. A review of Resident 3's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on 7/5/19, and last	{F 711}		

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{F 711}	Continued From page 13 readmitted on 8/23/19. Resident 3's diagnoses included anxiety (feeling of worry, nervousness, or unease), cocaine (strong addictive stimulant drug frequently used as a recreational drug) abuse, and altered mental status (disruption in how the brain works that causes a change in behavior). A review of Resident 3's Minimum Data Set (MDS), a standardized assessment and care screening, dated 8/2/19, indicated the resident was able to make her needs known and able to make her self understood. The MDS indicated Resident 3 required a one-person physical limited assist for ADLs. A review of Resident 3's Baseline Care Plan, revised on 8/27/19, indicated that Resident 3 had an uncertain discharge plan and the outcome was to provide three months of ancillary (wide range of healthcare services provided) services and treatment for her tuberculosis diagnosis. The staff goals included to initiate the discharge planning process, and for Resident 3 to have a safe and appropriate placement. A review of Resident 3's H/P indicated Resident 3 was seen by the Nurse Practitioner ([NP] an advanced practice registered nurse trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose illness and disease, prescribe medication and formulate treatment plans) on 7/27/19. A review of the unsigned physician's telephone order, dated 9/6/19 and timed at 9 a.m., indicated that Resident 3 was able to go on Out on Pass (OOP) for four (4) hours and as needed.	{F 711}		

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{F 711}	Continued From page 14 A review of the facility's document titled, "Release of Responsibility for Leave of Absence," indicated that Resident 3 signed the OOP log. on 9/4/19 at 11:30 a.m., and on 9/9/19 at 11:30 a.m. A review of the Multidisciplinary Team Notes indicated the following: 1. On 8/30/19 at 3:05 p.m., Resident 3 left the facility against medical advice (AMA). 2. On 9/4/19 at 11:40 a.m., staff called physician to request an OOP order for Resident 3. 3. On 9/6/19 at 9 a.m., clarification of the OOP order indicated that Resident 3 can go OOP for four hours and as needed. At 12:20 p.m., Resident 3 leaves the facility on OOP. 4. On 9/9/19 at 11:30 a.m., Resident 3 leaves the facility OOP and does not return. On 9/12/19 at 10:34 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) stated that Resident 3 should have been assessed prior to requesting an OOP order. LVN 1 stated that Resident 3 was initially seen by the NP and not the physician and that the facility's policy is for physicians to conduct the first visit assessment. On 9/12/19 at 11:50 a.m., during a concurrent interview and record review, the Director of Nurses (DON) stated that she was not aware that Resident 3 did not have a physician H/P completed and that Resident 3 was seen by the NP instead of the physician. The DON stated that the policy of the facility is for physicians to conduct their first initial visit. A review of the facility's policy, dated 1/2004 and titled, "Physician Visit," indicated that the facility	{F 711}		

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{F 711}	Continued From page 15 should ensure that each resident is under the care of a physician selected by the resident and the medical care is supervised by another physician when the attending physician is unavailable. The policy indicated that an H/P should be completed within 72 hours of admission. NP's or clinical nurse specialist of PA's may alternate with the physician as an option after the initial visit.	{F 711}		