STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview and record review the facility failed to develop a safe and effective discharge plan for one of three sampled residents (Resident 1) when Resident 1 was discharged to an assisted living facility (ALF-type of residence for older adults who need daily care) without an interdisciplinary team (IDT-variety of medical professionals who plan and coordinate patient care) meeting to develop discharge goals and post discharge care needs involving the resident's Public Guardian Conservator (PGC-a resident representative responsible for managing financial and medical decisions for a person who is incapacitated [physically or mentally unable to manage one's affairs]), and did not review a post discharge plan with the PGC prior to discharge according to the facility's policy and procedure. This failure placed Resident 1 at risk for his medical needs to go unmet after discharge. Findings: During a review of Resident 1's Order Summary Report, (OSR) dated 12/6/2023, the OSR indicated, . order to d/c [discharge] patient on 11/29/2023 with all medications to [Name of ALF] . During a review of Resident 1's Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included difficulty in walking, hypertensive heart disease (heart disease caused by high blood pressure), diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage caused by diabetes), dementia (loss of memory, language, and other thinking abilities) with agitation (state of anxiety or nervousness), Alzheimer's Disease (progressive disease where dementia symptoms worsen), and hyperglycemia (high blood sugar). During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 12 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was moderately impaired. During an interview on 6/20/24 at 10:46 a.m. with LVN 1, LVN 1 stated social services would initiate resident discharges and notified the nurses of the date so the nurses could perform any resident education needed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/20/24 at 10:56 a.m. with the Supervising Registered Nurse (SRN), the SRN stated the discharge process was initiated by social services (SS). The SRN stated SS would contact the resident's physician and request the discharge orders. The SRN stated the nurses were responsible to provide education on disease processes, medication and any procedures needed. Resident 1's Physician's Report for Residential Care Facilities for the Elderly, dated 11/27/23 was reviewed. The form indicated, . NOTE TO PHYSICIAN . The license requires the facility to provide primarily non-medical care and supervision . THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE . Primary diagnosis . Type 2 diabetes mellitus with hyperglycemia . Diabetes mellitus with diabetic neuropathy . Can patient manage own treatment/medication/equipment . No . Able to Administer Own Prescription Medications . No . The SRN stated Resident 1 required insulin and fingerstick blood sugars and would need the capability of learning to administer them to himself if he were to be discharged to an ALF. The SRN stated Resident 1 would need a caregiver involved to assist with the medication and fingerstick blood sugars after discharge. During a concurrent interview and record review on 6/20/24 at 12:15 p.m. with Social Services Director (SSD) and Social Services Assistant (SSA) Resident 1's Electronic Medical Record (EMR) was reviewed. The SSA stated the owner of Redwood Village Assisted Living had visited the facility in 11/2023 and requested to speak to residents who might be interested in moving into his facility. The SSA stated she and the SSD asked Resident 1 if he was interested in possibly moving and he said yes, so the owner of the assisted living spoke with Resident 1. The SSA stated Resident 1 wanted to be discharged to the ALF and they were aware he was not safe to discharge to the community without assistance. The SSA stated she contacted Resident 1's Public Guardian to notify him Resident 1 wanted to be discharged to the ALF. The SSA stated the normal discharge process was for the IDT to meet every Friday and discuss potential discharges including the post discharge care needed for a safe discharge. The SSD stated she or the SSA would prepare the residents discharge, set up any aftercare needed, including medications, home health or durable medical equipment. The SSA was unable to provide any documentation to indicate Resident 1's discharge had been discussed by the IDT. The SSA stated the resident representative would need to be included in the discharge planning process to ensure the resident received appropriate care after discharge. The SSA stated Resident 1 had a PGC who was notified the facility was planning to discharge the resident but was unable to provide any documentation which indicated the PGC was included in the discharge planning. The SSA stated Resident 1 had diabetes mellitus and received insulin and fingerstick blood sugar checks while in the facility. The SSA stated the ALF was unable to administer insulin and Resident 1 had dementia, so she contacted the physician to discuss the insulin and the physician discontinued the insulin and continued the oral (by mouth) medication. The SSA reviewed Resident 1's EMR and was unable to provide documentation the PGC had been notified the insulin was discontinued for discharge to the ALF. The SSD stated Resident 1's discharge order was on 11/29/24, but he did not discharge from the facility until 12/6/24. The SSD was unable to provide documentation to indicate if the PGC was notified of the final discharge plan or when the resident left the building. The SSA and SSD were unable to provide a discharge plan care plan indicating Resident 1's goals and interventions for discharge. During a review of Resident 1's Nurses Notes, dated 12/6/23 at 8:41 a.m., the note indicated, . Resident discharge to [NAME] Village Facility. All order current medicines and belongings are with resident. VSS [vital signs stable]. Lung sounds clear no distress noted no pain. Pt [patient] leftg [sic] building with [NAME] [owner of the ALF]. 0840 [8:40 a.m.] . (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/17/24 at 9:56 a.m. with the PGC, the PGC stated Resident 1 had been under conservatorship of the Public Guardian's Office since 2015 and he had been Resident 1's conservator for a few years. The PGC stated Resident 1 was diabetic, and his blood sugar was difficult to control because the resident liked to snack. The PGC stated the facility contacted him on 11/29/23 and informed him they were looking to move him [Resident 1] out [of the facility]. The PGC stated social services told him a representative of an ALF had met with Resident 1 and Resident 1 wanted to move to the ALF. The PGC stated, they told us they could no longer provide for his needs. The PGC stated he was assured Resident 1 would receive the same level of care at the ALF which included the resident's insulin and fingerstick blood sugar tests. The PGC stated he would not have agreed to Resident 1's if he had been notified the resident would not receive his insulin or blood sugar checks. The PGC stated his office believed the level of care would not change. The PGC stated the facility had initiated the discharge because the Public Guardian's Office was called and requested to allow for the discharge to the ALF. The PGC stated he was not contacted by the facility to participate in the actual discharge planning and was not notified by the facility when Resident 1 was discharged . The PGC stated Resident 1 had dementia and Alzheimer's Disease and would not be able to retain discharge instructions or education provided for any length of time. During a telephone interview on 7/17/24 at 10:31 a.m. with physician (PHY) 1, PHY 1 stated Resident 1 was contacted by the SNF and notified Resident 1 wanted to discharge to the ALF. PHY 1 stated he was told the ALF could not administer insulin, so he discontinued it because Resident 1 did not want to be poked any longer. PHY 1 stated Resident 1 was supposed to find a new primary care provider and have an appointment within 1-2 weeks. When asked if PHY 1 had discussed Resident 1's discharge with his PGC, PHY 1 stated he had not and the SNF was handling the discharge. During a review of an e-mail sent by the facility's administrator (ADM) on 7/18/24 at 4:39 p.m., the ADM indicated the facility did not have Resident 1 social services notes related to discharge or copies of the discharge paperwork. During a review of the facility's policy and procedure (P&P) titled Transfer or Discharge, Facility-Initiated, dated 10/2022, indicated, . Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy . discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected . Facility-initiated transfer or discharge means a transfer or discharge . did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care . Orientation for Transfer or Discharge (Planned) . A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility . (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Transfer or Discharge, Resident-Initiated , dated 10/2022, indicated, . Residents may initiated a transfer or discharge from the facility . Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected . Resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility . For resident- initiated discharges, the medical record contains . documentation or evidence of the resident' or resident representative's verbal or written notice of intent to leave the facility . a discharge plan . documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for discharge care .