STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055917	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvest Crossing Post Acute	469 East North Street Manteca, CA 95336

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Notice of Discharge (NOD-written notice that explains the reason for discharge, includes the effective date and discharge location, informs the resident of the right to appeal, provides contact information for the Long-Term Care (LTC) Ombudsman - independent advocate who protects residents' rights, and requires a copy to be sent to the LTC Ombudsman) for one of three sampled residents (Resident 1) when the facility did not readmit Resident 1 following hospitalization, resulting in a facility-initiated discharge without a completed NOD, without documented physician clinical justification, and without notification to the LTC Ombudsman. This failure resulted in Resident 1 being discharged without a clear and coordinated discharge plan, including continuity of care, placed Resident 1 at risk for an unsafe transition of care, and prevented timely Ombudsman advocacy and oversight to protect resident rights.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was re-admitted to the facility on [DATE] with diagnoses including non-ST elevation myocardial infarction (a type of heart attack), type 2 diabetes mellitus (a condition that causes high blood sugar), cervicalgia (neck pain), Alzheimer's disease (a disease that caused memory loss and affects thinking and behavior), hypothyroidism (an underactive thyroid gland that slows the body's metabolism), hypertension, depression, unspecified injury of head, dementia in other diseases with other behavioral disturbance (memory problems with behavior changes), and anxiety disorder.Review of Resident 1's referral communication record dated 2/18/26 at 10:41 AM indicated the facility's Director of Marketing (DM) notified the hospital that Resident 1 required a higher level of care and that the facility could not meet Resident 1's care needs. During an interview on 4/7/26 at 10:04 AM with the Nurse Case Manager (CM), the CM stated she was responsible for discharge planning for some residents and coordinated with the interdisciplinary team (IDT-nursing, therapy, social services, and case management), communicated with the resident and family, and prepared for a safe discharge based on the resident's condition. The CM stated the discharge process required providing a Notice of Discharge to the resident prior to discharge, which included in the notice the discharge date , discharge location, reasons for discharge, and the resident's rights to appeal, and required that a copy of NOD be sent to the LTC Ombudsman. The CM stated that if the LTC Ombudsman was not notified of the resident's discharge, the Ombudsman could not follow up with the resident if needed.During a concurrent interview and record review on 4/7/26 at 10:29 AM with the Director of Nursing (DON), Resident 1's Notice of Transfer [NOT], dated 1/31/26, was reviewed. The NOT indicated Resident 1 was transferred from the facility to Hospital 1 related to a fall and that a copy of the NOT sent to the LTC Ombudsman identified Hospital 1 as the transfer location. The DON stated Resident 1 was later transferred from Hospital 1 to Hospital 2 for further evaluation, but the NOT sent to the LTC Ombudsman was not updated and did not reflect Resident 1's actual location at Hospital 2. The DON acknowledged that inaccurate or incomplete information in the NOT could prevent the LTC Ombudsman from knowing Resident 1's location and delay or limit follow-up. The DON stated the facility did not readmit Resident 1 after hospitalization on 2/18/26, which resulted in a facility-initiated discharge. The DON acknowledged a Notice of (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discharge was required to be provided to Resident 1 and Resident 1's family but was not completed on 2/18/26, which placed Resident 1 and Resident 1's family at risk of not being informed of appeal rights, not understanding the reason for discharge, lacking a confirmed discharge location, and gaps in safety. The DON stated no notice was sent to the LTC Ombudsman, leaving the LTC Ombudsman unaware of Resident 1's discharge and unable to provide timely advocacy and oversight. The DON stated the facility did not readmit Resident 1 due to a higher level of care need, and there was no documentation in Resident 1's Electronic Health record (EHR-computerized medical chart used to document care) that a physician assessed, evaluated, determined, or specified the need for a higher level of care. The DON stated a physician assessment was required to support the determination that Resident 1 required a higher level of care and to ensure appropriate follow-up.During an interview on 4/7/26 at 4:10 PM with the LTC Ombudsman, the LTC Ombudsman stated she received a Notice of Transfer on 1/31/26 for Resident 1 that identified Hospital 1 as the transfer location. The LTC Ombudsman stated when Resident 1 was subsequently transferred to Hospital 2, the facility did not provide an updated notice reflecting the change in location. The LTC Ombudsman further stated that when the facility decided not to readmit Resident 1 after hospitalization in February, she did not receive a Notice of Discharge. The LTC Ombudsman further stated that when the facility did not provide accurate or updated notices, including a Notice of Discharge, the LTC Ombudsman was not fully informed of the residents' status and was unable to provide advocacy support or assist the residents in maintaining their rights.Review of facility's policy and procedure (P&P), titled Transfer or Discharge Notice revised in 3/2021, the P&P indicated .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.Residents are permitted to stay in the facility and not be transferred or discharged unless: a. the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. b. the transfer or discharge is inappropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.the notice [Notice of Discharge] is given as soon as it is practicable.The resident and representative are notified in writing of the following information: a. The specific reason for the transfer/discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge.f. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman.A copy of the notice [Notice of Discharge] is sent or the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.Review of facility's policy and procedure (P&P), titled Discharge Summary and Plan revised in 10/2022, the P&P indicated .Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan.The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge.Review of facility's policy and procedure (P&P), titled Attending Physician Responsibilities revised in 8/2014, the P&P indicated .Supporting Resident Discharges and Transfers.The Attending Physician will follow up (as needed) with another physician or health-care practitioner who is to assume the care of an acutely ill or unstable patient, either in the facility or in another setting.The Attending Physician will provide documentation and/or information needed for care continuity at a receiving facility.