| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055922 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Courtyard Health Care Center | 1850 East 8th Street<br>Davis, CA 95616 |

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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate discharge for one of three sampled residents (Resident 1), when 1. The facility did not follow physician discharge orders;2. The 30-day notice of discharge was given to Resident 1 at time of discharge; 3. The facility failed to develop post discharge care follow up for a June neurology referral; 4. There was no physician discharge summary in the medical records; and5. Minimum Data Sheet (MDS - a federally mandated resident assessment tool) discharge assessment was incomplete and not submitted. These failures led to inappropriate discharge of Resident 1 from the facility and reduced the facility's potential in discharging Resident 1 safely.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility in April 2025 with diagnoses that included benign neoplasm of cerebral meninges (brain tumor), cognitive communication deficit, and symptoms and signs involving cognitive functions and awareness. Resident 1's MDS indicated Resident 1 had severe cognitive impairment.During a review of Resident 1's Order Summary Report (OSR), dated 7/3/25, the OSR indicated May discharge with home health RN (registered nurse)/PT (physical therapy- focuses on restoring, maintaining and improving a person's ability to move and function)/OT (occupational therapy- focuses on improving a person's ability to perform tasks, develop skills and maintain independence in their daily routine). During a review of Resident 1's Discharge Information/Recapitulation of Stay, dated 7/3/25, Resident 1 was discharged to .Hotel [name of hotel] . The form further indicated. Home Health Services Required & Home Health Agency Contact Information: [home health agency name] . (pending approval) .During a review of the information received by the Department, dated 7/8/25, the information indicated, .recovering from a craniotomy surgery (brain surgery) . (Resident 1) was discharged to a motel for several days. (Resident 1) was found near the hotel in Downtown Davis; confused. He was brought to (hospital name). (Resident 1) has been non-verbal during his hospitalization. (Resident 1) was not safe to discharge from Courtyard back to the community given his cognitive deficits.During a review of Resident 1's Speech Therapy Discharge summary, dated [DATE], the speech therapy notes indicated that Resident 1 .[had] difficulty following directions. [Resident 1] requires max [maximum] cues.memory impaired [decline in the ability to remember things whether recent events, past memories, or both].During a concurrent interview and record review on 7/10/25 at 2:53 p.m. with the Social Services Director (SSD), the SSD confirmed that Resident 1 was discharged to a hotel for three days. SSD reviewed and confirmed that home health agency was still pending and was not established prior to discharge. The SSD confirmed that the facility did not follow through on a June neurology referral and no documented evidence of post discharge care follow on the neurology appointment was in the medical records. During a concurrent interview and record review on 7/10/25 at 3:16 p.m. with the MDS Coordinator, the MDS Coordinator confirmed that cognition assessment and mood assessment were not done. During a concurrent interview and record review on 7/10/25 at 3:29 p.m. with Director of Nursing (DON), the DON reviewed and confirmed that there was no doctor's discharge summary in Resident 1's medical record. The facility was not able to provide documented evidence when asked. During a concurrent interview and record review on 7/10/25 at 3:45 p.m. with the Administrator (ADM), the ADM agreed and confirmed that the facility did not safely discharge Resident 1. The ADM confirmed that the doctor's orders for discharge were not followed through. The ADM further confirmed that the 30-day notice should have been given to the resident 30 days prior and not at the time of discharge, to give the resident enough time to appeal the planned discharge. During a review of the facility ' s policy and procedure (P&P) titled Admission, Transfer, Discharge and bed-holds dated December 2016, the P&P indicated, .Before a resident is.discharged , the facility will notify the resident.notice will be made at least 30-days prior to.discharge, or as soon as practical.the facility will comply with all state and federal guidelines regarding medical record documentation for.discharges, as well as communication to receiving health care institutions or providers, including physician documentation requirements.the facility will provide sufficient preparation and orientation to resident.in order to ensure a safe and orderly discharge from the facility.During a review of facility's P&P titled Submission and Correction of the MDS Assessments.5.2 Timeliness Criteria, dated October 2024, indicated For.discharge.assessment, encoding must occur within 7 days. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident safety for one out of three sampled residents (Resident 1) when Resident 1 eloped from the facility and failed to implement interventions per facility policy. This failure reduced the facility's potential in keeping Resident 1 safe from harm.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility in April 2025 with diagnoses that included benign neoplasm of cerebral meninges (brain tumor), cognitive communication deficit, and symptoms and signs involving cognitive functions and awareness. Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) indicated Resident 1 had severe cognitive impairment.During a review of Resident 1's Speech Therapy Discharge summary, dated [DATE], the speech therapy notes indicated that Resident 1 .[had] difficulty following directions. [Resident 1] requires max [maximum] cues.memory impaired [decline in the ability to remember things whether recent events, past memories, or both].During a review of Resident 1's Social Services progress notes, dated 7/2/25, indicated that . (Resident 1) .exited out the building.During a review of Resident 1's medical records, indicated no documented evidence of elopement care plan done, no documented evidence of elopement assessment or change of condition done.During an interview with Licensed Nurse 1 (LN 1) on 7/10/25 at 2:44 p.m., LN 1 stated that Resident 1 is more confused, is only oriented to himself. During a concurrent interview and record review on 7/10/25 at 2:53 p.m. with Social Services Director (SSD), the SSD confirmed Resident 1 was found at the liquor store by staff members. Resident 1 was [NAME] back to facility by a licensed nurse. The SSD further stated that Resident 1 likes to walk and wander. SSD confirmed that there was no additional documentation of elopement from nursing staff regarding the reported incident. During a concurrent interview and record review with Administrator (ADM) on 7/10/25 at 4:30 p.m., the ADM confirmed that facility did not take measures to assess and implement interventions for Resident 1's elopement risks per policy.During a review of the facility policy and procedure (P&P), Elopement and Missing Resident dated December 2017, indicated, .An elopement occurs when a resident leaves the premises or a safe area without authorization of staff notification.assessment guidelines may include.nursing assessment.elopement risk assessment, changes in condition and IDT (interdisciplinary) Walking Rounds Review.if wandering or exit seeking behavior is identified, a change of condition IDT Walking Rounds should be completed.complete a Report of incident.ensure the incident and events are documented objectively in the resident record.The Administrator reports the incident to the State Regulatory/Licensure Agency according to regulation. |