STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055922	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Health Care Center	1850 East 8th Street 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) discharged appropriately when:1. Final discharge instructions were not reviewed with the Durable Power of Attorney (DPOA-a legal document that gives one person the authority to make medical decisions for another person),2. Resident 1 was discharged without needed supplies (tube feeding formula and a glucometer),3. Discharge orders were to discharge home with home health; however, Resident 1 was discharged to a board and care, and4. No clinical evaluation was completed for Resident 1 to determine discharge needs and/or discharge potential.These failures placed Resident 1 at risk for potential harm due to inadequate discharge planning, lack of continuity of care and an increased risk of deterioration in the resident's health status resulting from absence of appropriate clinical oversight. Findings:Resident 1 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain function disruption due to chemicals in the body), severe protein-calorie malnutrition, and cognitive communication deficit (difficulties in communication that arise from impairments in thinking, learning, and remembering). Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 10 out of 15 which indicated Resident 1 was moderately impaired in cognition. Resident 1 was discharged from the facility on 7/29/25 to a board and care, a non-medical residential setting that provides room, board, supervision and assistant with activities of daily living, not licensed to provide skilled nursing care.During a telephone interview on 7/30/25 at 2:08 p.m. with DPOA of Resident 1, the DPOA/RP (also a Responsible Party) voiced that Resident 1 had been discharged unsafely from the facility. The DPOA/RP stated Resident 1 lacked capacity for healthcare decisions and the facility did not review discharge instructions with him, Resident 1's DPOA and RP, prior to Resident 1's discharge. The DPOA stated the facility had not provided needed tube feeding formula for Resident 1 at the time of discharge and expressed his concerns that Resident 1 could be re-hospitalized for high blood sugars because Resident 1 did not have access to a glucometer. During an interview on 7/31/25 at 2:36 p.m. with Assistant Director of Nursing (ADON) 1, ADON 1 stated she discharged Resident 1 from the facility to a board and care on 7/29/25. ADON 1 stated she was aware Resident 1 was not her own RP and it was expected to review discharge instructions with the RP. When ADON 1 was asked if it was appropriate to go over discharge instructions with a resident who lacked capacity, ADON 1 answered, No. ADON 1 further stated she reviewed Resident 1's Recapitulation of Stay (ROS) dated 7/29/25, with Resident 1 and acquired Resident 1's signature. ADON 1 further stated she discharged Resident 1 from the facility without tube feeding formula, although she was aware Resident 1 had a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube for supplemental feedings. ADON 1 further stated Resident 1 required blood sugar checks and was discharged from the facility without a glucometer. ADON 1 stated when she spoke with the DPOA after she had discharged Resident 1, the DPOA was frustrated that she had not gone over discharge instructions with him prior to Resident 1's discharge.During a concurrent interview and record review on 7/31/25 at 4:46 p.m. with Director of Nursing (DON), Resident 1's Medical Record (MR) was reviewed. The DON confirmed Resident 1 had been discharged to a board and care on 7/29/25. The DON stated the MD (Physician) phone order, dated 7/25/25 and signed by Nurse Practitioner (NP) 1, indicated, May discharge home with home health RN (Registered Nurse)/PT(Physical Therapy)/OT(Occupational Therapy) and DME (Durable Medical Equipment-such as glucometer, wheelchairs, oxygen equipment, etc) if needed. The DON stated the order should have been updated to reflect discharge to a board and care. The DON further stated it was the expectation for the provider to assess the resident prior to discharge. The DON stated Resident 1's Medical Record (MR) contained three provider assessments titled, MD/NP/PA (Physician Assistant) dated 6/19/25, 7/17/25, and 7/22/25, and confirmed none of the assessments indicated Resident 1 was ready for discharge or addressed the resident's discharge potential. When the DON was asked to provide any clinician assessments or progress notes indicating Resident 1 was safe to discharge, the DON was not able to provide one. During a phone interview on 8/4/25 at 1:26 p.m. with NP 1, NP 1 verified she had given the phone order for Resident 1, dated 7/25/25, which indicated, May discharge home with home health RN/PT/OT and DME if needed. NP 1 explained that her discharge order for Resident 1 was May discharge to home. When questioned about the discrepancy between this order and the resident's actual