STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Oak Nursing and Rehabilitation Center	4635 College Oak Drive Sacramento, CA 95841

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and appropriate discharge was provided to one of three sampled residents (Resident 1), when Resident 1 was not permitted admission to the facility upon return from a day leave and was discharged to her car.This failure resulted in Resident 1's unanticipated discharge and homelessness with no resources, medical care, or information on how to file an appeal.On 10/23/25 at 1:52 p.m. an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Administrator (Admin). The IJ began on 9/24/25 when the facility failed to reassess or allow readmission to Resident 1 which resulted in Resident 1's homelessness. The Admin was informed of the facility's failure to follow discharge protocols to ensure resident safety and rights were protected.On 10/29/25 at 11:37 a.m. during an onsite visit, the Department verified and confirmed the IJ was removed after the facility presented an acceptable plan of action (POA, interventions to correct the deficient practice) which included:An offer to Resident 1 to be readmitted to the facility;Placement options to Resident 1 in several locations and different levels of care;Hotel accommodations while working with the Resident on options;Immediate in-service training to facility staff regarding the discharge process and education surrounding F627, proper documentation, and what constitutes a resident leaving against medical advice (AMA);Resident leave of absence (LOA) process and policy review and training to all staff;Audits to the LOA binder and orders to ensure facility policy is followed; and,Facility interdisciplinary team (IDT, a team consisting of healthcare professionals across several fields of care) reviewed all AMA discharges to ensure proper and consistent process is followed and documented.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included a right femur (thigh bone) fracture, history of venous thrombosis (blood clot in the veins of the legs), embolism (when the blood clot breaks off and travels to another part of the body, commonly the lungs), localized edema (swelling from trauma, surgery or thrombosis), and chronic kidney disease (damage and dysfunction to the kidneys). During a review of Resident 1's Nurse Practitioner Progress Notes (NPPN) dated 7/31/25 at 10:36 p.m., the NPPN indicated Resident 1 was a high risk for re-hospitalization.During a review of Resident 1's Minimum Data Set (MDS, federally mandated resident assessment tool), dated 9/5/25, the MDS indicated Resident 1 was cognitively intact and capable of making her own decisions. During a review of Resident 1's Order Review History Report (ORHR, physician orders), the ORHR indicated an order, dated 9/5/25, for skilled physical therapy (PT) for five times a week for four weeks which included gait training, wheelchair mobility and neuromuscular re-education (a therapy that improves muscle strength, coordination, and timing after an injury by retraining the body's communication between nerves and muscles). The PT order indicated Resident 1's long term goal would be the ability to demonstrate transfers and ambulation with moderate independence (the ability to perform a significant portion of a task but still need help with other parts, typically involving about 50% assistance from a caregiver or the use of an assistive (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	device).During a review of the Discharge Summary, dated 9/11/25 at 10:27 a.m., the physician documented, Discharge disposition to: Transfer pt [patient] to custodial [personal care or long-term support and is focused on meeting a person's basic needs to ensure their comfort and dignity] until placement is secured. Pt needs placement because she is homeless. [Resident 1] will be transferred back to custodial care until a placement is secured.During a review of Resident 1's Care Plan Conference Notes, dated 9/18/25 at 10:42 a.m., the notes indicated Resident 1's discharge plan was to transfer from skilled to custodial care until placement was secured.During a review of the Social Services Notes, dated 9/24/25 at 2:33 p.m., the Social Services Assistant (SSA) documented, [Due to] patient being out more than 4 [hours], it will be an AMA discharge. During a review of the Social Services Note, dated 9/24/25 at 2:45 p.m. the Social Services Director (SSD) documented, The Nurse Practitioner (NP) has been notified and is in agreement with proceeding with discharge. The resident's belongings and medications will be prepared and made available for pick-up.During a review of Resident 1's Nursing Progress Notes (NPN), dated 9/24/25 at 5:18 p.m., the Director of Nursing (DON) documented, The resident came back to the facility at [4 p.m.] and it was discussed with the resident that the MD [Medical Director] has DC'd [discharged] the resident AMA.During a review of a physician's order dated 9/24/25 at 6:23 p.m. the order indicated, Resident discharge against medical advice .During a review of Resident 1's NPPN, dated 9/26/25 at 2:24 p.m. the NPPN indicated, Per the nursing notes, Resident 1 left AMA from the facility. The NP indicated she was not in the facility at the time of discharge.During a review of Resident 1's NPN, dated 9/24/25 through 9/26/25, there was no documentation which indicated Resident 1 had the desire to leave the facility AMA. The NPN did not include documentation that the risks and benefits of leaving the facility were discussed with the resident, options or locations that would meet Resident 1's needs having been presented to the resident, or if Resident 1 understood the reason for being discharged and her response to the discharge.During a telephone interview on 10/7/25 at 4:38 p.m. with Resident 1, Resident 1 stated the discharge occurred on 9/24/25, while she was out on private business for a LOA from the facility. Resident 1 indicated that when she returned to the facility that same day, staff notified her she could not return as a resident, failed to assess her after her LOA, packed up her belongings, discharged her to her car, and the facility stated the resident's discharge was considered as Against Medical Advice. Resident 1 indicated the facility wanted her to sign the AMA form, which she refused to sign, because it was not her decision. Resident 1 stated, I'm homeless, I wasn't trying to leave against medical advice, that wasn't my decision, I didn't want to leave. Resident 1 further stated, I was pretty traumatized that day, what do I do now? They made my life hell; their intention was to get rid of me and they did. Resident 1 indicated her discharge plan was to find placement in transitional housing and confirmed she is still unhoused.During a concurrent interview and record review on 10/8/25 at 3:51 p.m. with the Assistant Director of Nursing (ADON), Resident 1's medical record and the facility's Policy and Procedure (P&P) for LOA was reviewed. The ADON confirmed there was no documented evidence in Resident 1's medical record that indicated staff attempted to contact the MD for an LOA order. The ADON stated staff should have contacted Resident 1's MD to request an LOA order, and documented the date and time of the request, the MD's decision and that education was provided to the resident in the resident's medical record. The ADON stated, [Resident 1] was going on LOAs, the last day [9/24/25] she overstayed her LOA. The ADON confirmed the LOA P&P did not indicate a time limit for an LOA or that a resident will be discharged if the LOA P&P was not followed.During a concurrent interview and record review on 10/8/25 at 4:01 p.m. with the Social Services Director (SSD), Resident 1's medical record was reviewed from June 2025 through September 2025. The SSD acknowledged Resident 1 did not have a physician's order for an LOA. The SSD confirmed there was no documentation prior to 9/24/25 in Resident 1's medical record that discussed the facility's LOA process or procedure, the allotted hours Resident 1's insurance authorized for an LOA or that Resident 1 had been non-compliant with her plan of care. The SSD stated Resident 1 had been homeless when she was admitted to the facility and was on a transitional (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	housing waitlist. The SSD stated, Every day [Resident 1] would take off from the facility and would stay over five or six hours. I provided [Resident 1] with housing resources, but at that point it's on the resident to follow through with the discharge placement. The SSD stated, On that day [9/24/25] [Resident 1] left the facility around 10:30 a.m. and the decision to discharge her was because the resident chose to drive her own car instead of having a ride. The SSD indicated for a resident's transfer or discharge the facility needed to provide the resident with a Notice of Transfer or Discharge form which included information on how to file an appeal if the resident did not agree with the transfer or discharge. The SSD confirmed there was no documentation provided to Resident 1 upon her discharge due to the physician's order to discharge her as AMA. The SSD stated, We have to follow the doctor's orders. [Resident 1] did have a discharge plan, but she could not return to living in her car, [Resident 1] is homeless. The SSD admitted , I wouldn't discharge a [resident] to their car. That's not a safe discharge. The SSD acknowledged Resident 1 did not initiate the AMA discharge. During an interview on 10/23/25 at 11:37 a.m. with the DON, the DON acknowledged AMA discharges were resident initiated, not facility initiated, and confirmed the facility was not allowed to discharge a resident while on a LOA. The DON acknowledged that when a resident expressed a desire to leave AMA the facility should educate the resident, explain the risks and benefits of an AMA discharge, and provide follow-up information on where to get additional care and document the discussion in the resident's medical record. The DON stated, Since [Resident 1] was gone for more than four hours, the MD decided to DC the resident AMA.During an interview on 10/23/25 at 12:32 p.m. with the Admin, the Admin acknowledged if a resident verbalized a desire to leave the facility AMA then staff should attempt to provide the resident with education, the risks and benefits between leaving the facility versus staying at the facility, supplies, and additional resources. The Admin indicated if a resident returned to the facility after an identified LOA timeframe, the facility should have ensured the resident was safe and provided the resident with education on following MD orders and the facility's LOA P&P.During a telephone interview on 10/23/25 at 1:18 p.m. with MD 1, MD 1 confirmed an AMA discharge, by definition, was initiated by the resident. MD 1 stated if a resident indicated they wanted to leave the facility AMA and he [MD 1] was not at the facility at the time, he expected the facility staff to document the conversations between the resident and staff which discussed the resident's options, encouragement for the resident to remain in the facility, what the negative outcomes might be if the resident left the facility and what specific medical advice was provided to the resident. MD 1 stated, No, I would not discharge a resident to ?on the street'.During a telephone interview on 10/28/25 at 11:27 a.m. with Resident 1, Resident 1 confirmed she has been living in her car, in a parking lot, since her discharge from the facility on 9/24/25. Resident 1 stated, Emotionally and mentally, I'm gutted.this is very traumatic.and I'm very depressed. Resident 1 stated the healing to her right leg has deteriorated significantly and has continued to swell. Resident 1 stated her right leg is very weak and indicated the need for continued rehabilitation to regain strength and endurance. Resident 1 reported severe pain in her legs and hips, after sleeping in her car. Resident 1 has some blankets and a pillow but continues to worry about the colder weather and rain. Resident 1 stated she will need to relocate to a different parking lot, since her current location was prone to flooding. Resident 1 confirmed her last entry in the LOA binder was 9/24/25 at 10:30 a.m. and when she had returned to the facility at 4 p.m. she expressed that she wanted to be permitted to return.During a review of the facility's policy and procedure (P&P) titled, Resident Leave of Absence, dated 8/2006, the P&P indicated, Each resident leaving the premises (excluding transfers/discharged /appointments) must obtain an MD order for approved leave of absence (LOA).During a review of the facility's P&P titled, Discharging a Resident Without a Physician Approval revised October 2022, the P&P indicated, A physician's order is obtained for discharges, unless a resident or representative is discharging himself or herself against medical advice. 1. Should a resident. request an immediate discharge, the resident's attending physician is promptly notified. 4. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unsafe, the facility will. a) discuss with the resident.and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location; b) document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed; c) document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings; and d) determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.During a review of the facility's P&P titled, Transfer or Discharge, Resident Initiated, dated 10/2022, the P&P indicated, 3. a. Therapeutic leave is a type of resident-initiated transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.For resident-initiated discharges, the medical record contains: e. documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility; f. a discharge care plan; and g. documented discussions with the resident, or if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care. 2. The comprehensive care plan contains the resident's goals for admission and desired outcomes, which will be in alignment with the discharge if it is resident-initiated.During a review of the facility's P&P titled, Transfer or Discharge Notices, dated 3/2025, the P&P indicated, Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. Notice of Transfer or Discharge (Anticipated): 1. The resident and his or her representative are provided with a written notice of impending transfer or discharge at least 30 days prior to the transfer or discharge. 3. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis under S483.15(c)(1)(i)(A)-(F); b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider, description, and/or address if the location is a residence) to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: (1) the name, address, email, and telephone number of the entity which receives such appeal hearing requests; (2) information about how to obtain an appeal form; and (3) how to get assistance in completing and submitting the appeal hearing request; e. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; f. The Notice of Facility Bed-Hold and policies.

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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 ensure one resident out of three sampled residents (Resident 1) was provided with the required discharge notices, when Resident 1 was discharged from the facility.This failure resulted in Resident 1's denied access for advocacy and information for appeal options before being discharged unexpectedly to her car. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in [DATE] with diagnoses which included a right femur (thigh bone) fracture, history of venous thrombosis (blood clot in the veins of the legs), embolism (when the blood clot breaks off and travels to another part of the body, commonly the lungs), localized edema (swelling from trauma, surgery or thrombosis), and chronic kidney disease (damage and dysfunction to the kidneys).During a review of Resident 1's Minimum Data Set (MDS, federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 1 was cognitively intact and capable of making her own decisions.During a review of Resident 1's Care Plan Report (CPR), dated [DATE] and revised [DATE], Resident 1's CPR indicated Resident 1 would receive verbal and written discharge instructions. During a review of Resident 1's Care Plan Conference Notes, dated [DATE] at 10:42 a.m., the notes indicated Resident 1's discharge plan was to transfer from skilled to custodial care until placement was secured.During a review of a voicemail Resident 1 received from the SSD on [DATE] at 2:36 p.m. the SSD left Resident 1 a voicemail to formally inform her of the facility's decision to discharge her since she has been out of the facility for more than four hours. The SSD continued to reiterate the voicemail was a formal reminder to update and notify Resident 1 of the facility's decision to discharge her as AMA. The SSD indicated Resident 1 may return to the facility to sign paperwork, but she will not be able to stay at the facility. The SSD suggested if Resident 1 has a place to go, then Resident 1 should go there or Resident 1 should return to the emergency room for proper placement. The voicemail indicated a licensed nurse will give Resident 1 her paperwork and the facility will have her belongings available for pickup.During a review of the Social Services Note, dated [DATE] at 2:45 p.m. the SSD documented, The Nurse Practitioner (NP) has been notified and is in agreement with proceeding with discharge. The resident's belongings and medications will be prepared and made available for pick-up.During a review of Resident 1's Nurse Progress Notes (NPN) dated [DATE] at 5:18 p.m., the Director of Nursing (DON) documented, The resident came back to the facility at [4 p.m.] and it was discussed with the resident that the MD [Medical Director] has DC'd [discharged] the resident AMA.During a review of a physician's order dated [DATE] at 6:23 p.m. the order indicated, Resident discharge against medical advice .During a review of Resident 1's NPN, dated [DATE] through [DATE], there was no documentation which indicated Resident 1 had expressed the desire to leave the facility or if Resident 1 understood the reason for the unexpected discharged or her response to the discharge.During a telephone interview on [DATE] at 4:20 p.m. with the Ombudsman (an advocate for residents in nursing homes addressing issues related to care, safety, and residents' rights), the Ombudsman stated he had not received any recent reports or notifications for Resident 1's discharge from the facility. During a telephone interview on [DATE] at 4:38 p.m. with Resident 1, Resident 1 stated the discharge occurred on [DATE], while she was out on private business for a LOA (leave of absence) from the facility. Resident 1 indicated that when she returned to the facility that same day, staff notified her she could not return as a resident, failed to assess her after her LOA, packed up her belongings, and unexpectedly discharged her to her car. Resident 1 stated, I'm homeless, I wasn't trying to leave., that wasn't my decision, I didn't want to leave. Resident 1 further stated, I was pretty traumatized that day, what do I do now? They made my life hell; their intention was to get rid of me and they did. Resident 1 indicated her discharge plan was to find placement in transitional housing and confirmed she is still unhoused. Resident 1 confirmed the facility did not give her written notification or (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge instructions at the time of her discharge and stated she was unaware of her right to appeal the decision or who to contact for support or guidance. During a concurrent interview and record review on [DATE] at 4:01 p.m. with the Social Services Director (SSD), Resident 1's medical record was reviewed from [DATE] through [DATE]. The SSD indicated a Notice of Transfer or Discharge form, which included information on how to file an appeal if the resident did not agree with the transfer or discharge, was provided to the resident at least 30 days prior to the transfer or discharge, and a copy of the notice was sent to the local Ombudsman office. The SSD confirmed there was no documentation in Resident 1's medical record that indicated Resident 1 had been provided with the Notice of Transfer or Discharge form, prior to or on the day of her discharge. The SSD confirmed Resident 1 was not given the required notices. During an interview on [DATE] at 11:37 a.m. with the Director of Nursing (DON) the DON acknowledged the Notice of Transfer or Discharge form was provided to residents prior to their transfer or discharge from the facility and a copy of the notice was sent to the Ombudsman office. The DON confirmed the Notice of Transfer or Discharge was required under federal and state guidelines. During a follow-up telephone interview on [DATE] at 3:19 p.m. with the Ombudsman, the Ombudsman indicated he has not received any recent notifications regarding discharges from the facility and further stated, I have not received any [transfer or discharge] notifications from [the facility]. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, revised 3/2025, the P&P indicated, Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. 1.the resident and his or her representative are provided with a written notice of an impending transfer or discharge at least 30 days prior to the transfer or discharge. 3. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis under S483.15(c)(1)(i)(A)-(F); b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider, description, and/or address if the location is a residence) to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: (1) the name, address, email, and telephone number of the entity which receives such appeal hearing requests; (2) information about how to obtain an appeal form; and (3) how to get assistance in completing and submitting the appeal hearing request; e. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; f. The Notice of Facility Bed-Hold and policies. 4. A copy of the notice is sent to 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. During a review of the facility's P&P titled, Transfer of Discharge, Resident-Initiated, dated [DATE] the P&P indicated, . 3. Resident-initiated transfer or discharge means the resident.has provided verbal or written notice of intent to leave the facility. a. Therapeutic leave is a type of resident-initiate transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.