STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Summerfield Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1280 Summerfield Rd Santa Rosa, CA 95405	

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48660 Based on observation, interview and record review, the facility failed to permit two of three sampled residents (Resident 1 and Resident 2) to remain in the facility (Facility 1), when the facility initiated and transferred Resident 1 and Resident 2 to other skilled nursing facilities (Facility 2 and Facility 3) without providing evidence that Resident 1 and Resident 2 ' s health had improved sufficiently so they no longer needed the services provided by the facility, which was the reason given for the transfers. This failure caused emotional distress for Resident 1 and had the potential for emotional distress for Resident 2. Findings: During a concurrent observation and interview on 8/30/24 at 12 pm, Resident 1 was lying in her bed in Facility 1, visiting with Family Member A (FM A). Resident 1 stated the Social Services Director (SSD) came into her room on her fifth day as a resident in Facility 1 and told her a representative from another facility would be coming to speak with her. Resident 1 stated she thought the other facility was just trying to sell her on their facility. Resident 1 had not been informed a transfer was being arranged. Resident 1 stated on the morning of her sixth day in Facility 1, transport arrived to take her to Facility 2. Resident 1 further stated she was stunned as she was not aware she was moving. Resident 1 stated she did not understand why it was suggested she move to a one-star rated facility when Facility 1 was a five-star rated facility (a quality rating designed by the Centers for Medicare and Medicaid Services to assist consumers in choosing a care facility, with five stars being the best rating). Resident 1 stated she felt as though she would have been further along in her progress had she stayed at Facility 1 and not been transferred out to Facility 2, where she did not receive services per her physical and occupational therapy goals. During an interview on 8/30/24 at 12:15 pm, FM A stated that upon admission the SSD had informed her Resident 1 would be at Facility 1 for at least three weeks. FM A further stated she had not initiated a transfer to another facility for Resident 1 and had been very surprised when the transfer occurred. During an interview on 10/23/24 at 9:58 AM, Resident 1 stated she was so shocked when she was transferred to Facility 2 that she was afraid to leave her room and did not want to eat for several days. Resident 1 further stated she had no idea why she was transferred to Facility 2, and she was afraid she had offended someone at Facility 1. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a document titled, Admission Agreement, dated 5/23/24, indicated Resident 1 was the only person authorized to make decisions for herself. A record review of a document titled, Admission Record, for Resident 1 indicated an admitted [DATE], with diagnoses which included Sepsis (an overwhelming and life-threatening response to infection), Difficulty in Walking, Acute Transverse Myelitis of the Central Nervous System (an inflammation of the spinal cord which often damages nerve cells and can cause pain, muscle weakness, paralysis, sensory problems, or bladder and bowel dysfunction), and Depression (a mood disorder that can affect a person's thoughts, feelings, and ability to function in daily life). A record review of a document titled, History and Physical, dated 6/8/24, indicated Resident 1 was treated at an acute care facility for sepsis, stabilized, and then discharged to a SNF (Skilled Nursing Facility) for further care. New orders included rehabilitation with Physical Therapy (PT, therapy provided by an individual with specialized training that is used to preserve, enhance, or restore movement and physical function) and Occupational Therapy (OT, therapy provided by an individual with specialized training that is used to enhance or restored the ability to perform activities of daily living [ADLs]). PT and OT are considered Skilled Services. This document indicated Resident 1 ' s decision making capacity was intact. A record review of a Care Plan for Resident 2, dated 6/8/24, indicated, Wishes to return/be discharged to home. A record review of a document titled, Order Summary Report, signed and dated by Resident 1 ' s Attending Physician on 6/10/24, indicated, Resident has the capacity to make health care decisions. A record review of a document titled, Progress Notes-Social Services, dated 6/11/24, indicated, SS spoke with daughter regarding general update and projected Length of Stay (LOS) of 3+ weeks. Family is interested in transitioning patient from skilled to long-term care. A record review of a document titled, Occupational Therapy Treatment Encounter Note, dated 6/12/24, Indicated, OT and PT .required to successfully train and progress patient with slide board transfers and bed mobility d/t (due to) presenting with multiple deficits across both disciplines. A record review of a document titled, Brief Interview for Mental Status (BIMS), dated 6/13/24, indicated a BIMS Score of 15. A BIMS score of 15 indicated Resident 1 had intact cognition (capable of remembering, learning new things, concentrating, and making decisions that affect everyday life). A record review of a document titled, Progress Notes - Social Services, dated 6/13/24, indicated, SS (Social Services) informed resident and [FM A] that resident has been given a PT (patient) CHOICE transfer DC (discharge) of 6/14/24 @9:30 AM. A record review of a document titled, Notice of Transfer or Discharge, dated 6/13/24, showed a checkmark next to the phrase The resident ' s health has improved sufficiently that the resident no longer needs the services provided by this facility. The bottom of the document had a section titled, Verification of Receipt of Notice, and further indicated, This acknowledges that I have received a copy of this Notice of Transfer or Discharge. The notice had a hand-written note at the bottom which indicated, Verbal consent - [name of FM A] 6/13/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 9:13 am, the SSD stated the signature on the document titled, Notice of Transfer and Discharge, for Resident 1, was handwritten by her as, verbal consent, from FM A. When asked why the document was not signed by Resident 1, who was her own responsible party, the SSD stated Resident 1 was asleep when she went to her room. The SSD also stated the signature had not meant agreement with the transfer, but agreement that the notice of the transfer had been received. The SSD verified that none of the reasons for transfer or discharge listed on the document were valid for Resident 1. A record review of a document titled, Discharge Summary - Nursing, dated 6/13/24, indicated Resident 1 was admitted to Facility 1 for Post-Acute Care/Rehabilitation Services. The discharge summary indicated Resident 1 was provided with PT and OT treatments at Facility 1 to regain strength and abilities for ADLs. The discharge summary indicated, Pt (Resident 1) has potential to progress with further skilled services. A record review of a document titled, Physician Discharge Order, dated 6/13/24, indicated, Discharge reason: The resident ' s health has improved sufficiently so the resident no longer needs the services provided by the facility. This discharge reason was crossed out and replaced with the discharge reason of SNF-to-SNF transfer. During a concurrent interview and record review on 10/23/24 at 1:30 pm, when asked to provide documentation of Resident 1 initiating a transfer to another skilled nursing facility, the Director of Nursing (DON) was unable to do so. The DON stated a document titled, Nursing Progress Note, dated 6/14/24, indicated discharge instructions and paperwork were explained and signed by the patient. The DON verified this signature did not indicate initiation of a transfer by Resident 1. During a phone interview on 8/30/24 at 1:20 pm, Family Member B (FM B) stated Resident 2 was not available for an interview, as she had passed away while residing at Facility 3. FM B stated Resident 2 was in very bad shape when she was transferred from Facility 1 to Facility 3 as she was emaciated, dehydrated, and had a urinary tract infection (a bacterial infection that affects the urinary tract, which includes the bladder, urethra, and kidneys). FM B stated she was surprised when she was informed by the Social Services Department at Facility 1 that a transfer was imminent. FM B stated she had not requested for Resident 2 to be moved to a different facility and was shocked when she was told by Facility 1 staff that Resident 2 was ready for release. FM B stated she had inquired where Resident 2 would receive care, but she never requested to have her moved. A record review of a document titled, Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), anxiety disorder (a condition that causes excessive feelings of fear, dread, and worry that can interfere with daily life), severe protein-calorie malnutrition, dysphagia (difficulty swallowing), and Alzheimer ' s disease (a brain disorder that destroys memory and thinking skills). A record review of a Care Plan for Resident 2, dated 6/11/24, indicated, Wishes to return/be discharged to home. A record review of a document titled, Order Summary Report, dated 6/11/24 and signed by the Medical Director (MD), indicated, Resident has the capacity to make health care decisions. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of document titled IDT Care Plan Review, dated 6/12/24, indicated occupational and physical therapy would be provided five times per week to address mobility and activities of daily living deficits. The estimated length of stay was determined to be at least another two or three weeks. Document further notes that Resident 2 would require 24-hour care at home. The discharge plan summary indicated the following: Patient will return to the community when therapy and nursing services are completed. A record review of a document titled Speech Therapy Treatment Encounter Note, dated 6/13/24, indicated, Patient presents with acute .dysphagia. Continue to recommend puree solids and thin liquids with 1:1 supervision. The document also indicated, Recommend continued speech therapy (ST) intervention .to support adequate nutrition/hydration. A record review of a document titled, Brief Interview for Mental Status, dated 6/17/24, indicated a BIMS score of 7. A BIMS score of 7 indicated moderate cognitive impairment. A record review of a document titled, Physician Discharge Order, dated 6/18/24, indicated, Discharge reason: The resident ' s health has improved sufficiently so the resident no longer needs the services provided by the facility. This discharge reason was crossed out and replaced with the discharge reason of SNF-to-SNF transfer. A record review of a document titled, Progress Notes - Social Services, dated 6/19/24, indicated, SS (Social Services) informed resident and [FM B] that resident has been given a PT CHOICE DC of 6/19 @10:00 am. Resident will be transferring to Facility 3. A record review of a document titled, Notice of Transfer or Discharge, dated 6/19/24, showed a checkmark next to the phrase, The resident ' s health has improved sufficiently that the resident no longer needs the services provided by this facility. The bottom of the document had a section titled, Verification of Receipt of Notice, and further indicates, This acknowledges that I have received a copy of this Notice of Transfer or Discharge. The notice has a hand-written note at the bottom which indicated, Verbal consent - [name of FM B] 6/19/24 via telephone. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/24 at 12:05 pm, the SSD verified the therapy department assessed all admitted residents and determined skilled nursing needs, and Resident 1 and Resident 2 qualified for skilled nursing. The SSD stated the facility had skilled nursing beds that could have been converted to long term beds. The SSD stated she had not documented all conversations with residents and their representatives regarding transfers and discharges as she did not have enough time to do this. The SSD stated she wrote a note in the resident chart on the day the actual transfer occurred. When asked to provide documentation of Resident 1 and Resident 2 initiating a transfer to another Skilled Nursing Facility, she was unable to do so. The SSD stated Resident 1 and Resident 2 were given a choice of facilities to be transferred to. The SSD was unable to provide any documentation of facility choices. The SSD was asked to provide rationale for SNF to SNF transfer for Resident 1 and Resident 2 and was unable to provide any documentation of rationale for transfer. When asked what triggered the conversation regarding transfer to another facility, the SSD stated the Initial Care Conference triggered a conversation about options for other facilities if it was determined a resident was unsafe to return home. The SSD stated Initial Care Conference was scheduled during the first week of a resident ' s stay. The SSD also stated the document titled, Notice of Transfer or Discharge, did not contain an option for SNF-to-SNF transfer. Because of this, she had checked the box reading, The resident ' s health has improved sufficiently that the resident no longer needs the services provided by this facility. The SSD verified this was not the reason for Resident 1 ' s transfer to Facility 2 or Resident 2 ' s transfer to Facility 3. During an interview on 10/23/24 at 9:13 am, the SSD stated the signature on the document titled, Notice of Transfer and Discharge, for Resident 2, was handwritten by her as, verbal consent from FM B. The SSD also stated the signature had not meant agreement with the transfer, but agreement that the notice of the transfer had been received. The SSD verified that none of the reasons for transfer or discharge listed on the document were valid for Resident 2. During a concurrent interview and record review on 10/23/24 at 1:30 pm, when asked to provide documentation of Resident 2 initiating a transfer to another skilled nursing facility, the Director of Nursing (DON) was unable to do so. A record review of a facility policy and procedure titled, Criteria for Transfer and Discharge, dated 12/2023, indicated, Facility-initiated transfer or discharge - a transfer or discharge which .did not originate through the resident ' s verbal or written request.