

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Mayers Memorial Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 43563 Hwy 299 E Fall River Mills, CA 96028	

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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review the facility failed to ensure appropriate discharge (the safe release of a patient from a hospital, or medical facility when they are medically stable, able to manage self-care, or have arranged support) for one of two residents sampled (Resident 1) when:1. Resident 1 was transferred out of the skilled nursing facility (SNF - are places for people to live temporarily or permanently while they are getting rehabilitation and medical treatments after hospitalization for an illness or injury) to the acute care hospital (a healthcare facility where patients are treated for brief but severe episodes of illness or injury) due to a medical emergency and did not receive information regarding a 7-day bed hold form (a document that is signed by the resident or their representative which validates the resident's or their representative's agreement to the facility holding or reserving the resident's bed while the resident is absent from the facility for therapeutic leave [resident absences for purposes other than required hospitalization] or hospitalization) nor was she educated about her right to appeal her discharge (a resident's legal right to challenge a healthcare facility's decision to send them home or to another facility if they feel they are being inappropriately discharged) from the facility.2. No discharge physician's orders (the official directive from a doctor to a healthcare facility that a patient no longer requires inpatient care and can safely transition to another level of care, such as home) was found in Resident 1's record nor was there documentation of a conversation about Resident 1's discharge with Resident 1 or her representative.3. No change in condition assessment was completed after Resident 1 was transferred out of the skilled nursing facility.4. Resident 1's care plan was not updated with changes in her health status when she was transferred out of the skilled nursing facility.These failures violated Resident 1's right to be involved and prepared for discharge as well as the right to appeal the discharge and could potentially result in emotional distress for Resident 1.Findings:Review of Resident 1's medical record indicated that she was admitted to the facility on [DATE] with diagnoses which included paraplegia (loss of movement and/or sensation, to some degree, of the legs) and Chronic Obstructive Pulmonary Disease (COPD -a chronic lung disease causing difficulty in breathing).Review of Resident 1's Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 2/13/26 and completed by the Minimum Data Set Nurse (MDS) indicated a score of 15 out of 15 indicating good decision making ability.Review of Resident 1's record titled, Alert Charting Note dated 3/11/26 at 2:12 am and written by Licensed Nurse (LN A) indicated that Resident 1 was sent to the acute care hospital due to shortness of breath (difficulty breathing) and confusion.1. Review of a facility policy titled Bed Hold - SNF dated 2/4/16 indicated 1. For transfer to acute for illness, testing, or procedure, including surgery; c. Signature is required to acknowledge the resident, family, guardian, or Power of Attorney (POA - is a legal document that appoints someone to make healthcare decisions if the document's signer is unable to do so). If unable to get a signature; the nurse can do a telephone call to the responsible party (medical decision maker) verified by two nurses.During a concurrent interview and (continued on next page)</p>

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	<p>record review on 4/1/26 at 1:53 pm, with the Director of Nursing (DON), reviewed Resident 1's record titled Bed-Hold Information for SNF Residents Going to Acute Status undated, the DON acknowledged that this document did not include the signature of Resident 1, nor her responsible party. The DON confirmed that since the document was not signed by Resident 1 or her responsible party that it should have been signed by two nurses validating if Resident 1 or her responsible party agreed verbally (such as in person or over the phone) with the facility holding her bed. During a phone interview on 4/3/26 at 4:09 pm, with Family Member (FM), FM indicated that Resident 1 did not receive the Bed-Hold Information for the SNF Resident Going to Acute Status form or received any information about appealing her discharge from the facility. FM indicated that the only communication she has gotten had been that Resident 1's belongings are packed and ready to be picked up. FM indicated that Resident 1 was still at the acute care hospital and had not been able to come back home to the skilled nursing facility in her community.</p> <p>2. Review of a facility policy titled, Transfer and Discharge of Residents dated 5/5/22 indicated, Discharge Procedure: 1. Obtain, implement, and sign off Physicians orders. a. Time and date of discharge order, b. Resident destination, c. Disposition of medications (the finalized plan for managing a patient's prescriptions, including reconciliation [comparing hospital/home or other facility medications], prescribing new medications, and scheduling pharmacy pickups). And 8. Complete the Resident Transfer/Discharge Summary/Plan form and go over these instructions with resident &/or family member. During a concurrent interview and record review on 4/1/26 at 1:53 pm, with the DON, reviewed Resident 1's Orders Summary, the DON confirmed that there was no discharge physician's order for Resident 1. Reviewed Resident 1's Progress Notes, the DON confirmed that there was no documentation of a conversation with Resident 1 or her responsible party regarding Resident 1's discharge from the facility.</p> <p>3. Review of a facility policy titled Charting and Documentation revised 3/5/25 indicated, All skilled and unskilled services will be recorded, including but not limited to: Any significant change in condition. During a concurrent interview and record review on 4/1/26 at 4:05 pm, with the DON, reviewed Resident 1's progress notes from 3/11/26 to 4/1/26. The DON confirmed that no Change in Condition assessment had been completed.</p> <p>4. Review of a facility policy titled, Care Plans LTC revised 3/27/25 indicated The planning for care, treatment and services will include the following: Review and revision of the care plan, treatment, and services. During a concurrent interview and record review on 4/1/26 at 4:05 pm, with the DON, reviewed Resident 1's record titled, Care Plan date initiated 11/22/22. The DON confirmed that there were no updates to the care plan regarding Resident 1's transfer to the acute care hospital due to respiratory issues on 3/11/26.</p>		