

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2024
NAME OF PROVIDER OR SUPPLIER  Arlington Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3688 Nye Avenue Riverside, CA 92505	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</b></p> <p>Based on interview, and record review, the facility failed to provide an updated notice of transfer and discharge for one of three residents' (Resident 2) responsible party (RP) and the Long-term Care Ombudsman office to indicate the changes to the discharge location for Resident 2. This failure had the potential for Resident 2's RP and the Ombudsman not to be aware and be able to advocate for Resident 2's safe discharge.</p> <p>Findings:</p> <p>On March 27, 2024, at 10:43 a.m., an unannounced visit to the facility on a complaint investigation was initiated.</p> <p>A review of Resident 2's History and Physical dated December 22, 2023, indicated he had the capacity to understand and make decisions.</p> <p>On March 27, 2024, at 2:17 p.m., an interview was conducted with the Social Service Director (SSD). The SSD stated that Resident 2 was discharged to a board and care on March 25, 2024. The SSD stated that on March 25, 2024, she received a call from the transporter, informing her that the board and care (Board and Care 1) refused to accept the resident because he was male. The SSD stated that she called other board and care in the area to find placement for Resident 2. The SSD stated that she spoke with an employee at a board and care facility (Board and care 2), and they agreed to admit Resident 2 over the phone. The SSD stated that she emailed the paperwork to the new board and care (Board and Care 2) and provided the new address to the transporter. The SSD stated on March 26, 2024, she received a call from the social worker (SW) at the hospital, who informed her that Resident 2 was at their facility. The SSD stated that she was informed by the SW that the resident was found outside of the new board and care (Board and Care 2), and the board and care staff called 911. The SSD stated that they should have taken the resident back to the facility instead of finding another board and care. The SSD stated that Resident 2's family member and Ombudsman were not notified of the new location.</p> <p>On March 27, 2024, at 4:48 p.m., an interview was conducted with the facility administrator (ADMIN). The ADMIN stated that he was aware of Resident 2's discharge. The ADMIN stated that Resident 2's discharge was not the normal protocol that they follow.</p> <p>(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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 28, 2024, at 8:37 a.m., a telephone interview was conducted with the hospital's Social Worker (SW). The SW stated they received Resident 2 into the emergency roiaognom on [DATE]. The SW stated that the hospital staff called Resident 2's family member to find out where Resident 2 had been, prior to being found outside the board and care (Board and Care 2).</p> <p>On April 4, 2024, at 4:31 p.m., a telephone interview was conducted with [name of board and care 2] House Manager (HM). The HM stated that on March 25, 2024, at approximately 12:30 p.m., Resident 2 was found sitting outside of the residence. The HM stated that he was blind and hard of hearing, and was by himself. The HM stated that she had no idea where the resident came from and called 911 to assist him. The HM stated that she had not spoken to the SSD from the facility, nor did they accept to admit Resident 2. The HM stated that they have a resident named [name] who must have spoken to the SSD on the phone.</p> <p>A review of Resident 2's Notice of Proposed transfer/discharge date d March 21, 2024, indicated, Notice of Proposed Transfer/Discharge . Resident/Resident Representative:[name and phone number] . D. Name of Resident: [Resident 2's name] . E. Date of Discharge: 03/25/2024 . F. Disposition/Location:[address and name of Board and Care 1] .II. Ombudsman Services .Ombudsman Notified Of Transfer/Discharge Via: A. Fax .V. Verification of Receipt of Notice .This acknowledges that I have received a copy of this Notice of Proposed Transfer/ Discharge form .A. Printed Name of Resident or Resident Representative:[name of Resident Representative] . B. Resident/Resident Representative Signature: via telephone . C. Resident/Resident Representative Signature Date: 3/21/2024 .</p> <p>A review of Resident 2's 72-hour Charting dated March 25, 2024, indicated patient (sic) discharged .via gurney with the help of two [name] transport attendants on 3/25/24 at 10:46 . patient meds and belongings sent with transportation and patient.son (sic) .and MD notified</p> <p>A review of Resident 2's Social Service Note dated March 25, 2024, at 12:35 p.m., indicated Late Entry: received a call from transportation and they expressed that board and care would not accept pt [patient] due to he was a male .ssd (sic) called board and cares around the area and [name] from [name] board and care agreed for pt to admit .ssd (sic) gave new address to transport .</p> <p>A review of the facility's policy and procedure titled Transfer or Discharge Notice revised March 2021, indicated .5. The resident and representative are notified in writing of the following information .The location to which the resident is being transferred or discharged ; . 6. 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 .If the information in the notice changes prior to the transfer or discharge, the recipients of the notice are updated as soon as practicable .</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</b></p> <p>Based on interview and record review, the facility failed to ensure a safe and orderly discharge for one of three residents (Resident 2), when Resident 2 was discharged to a Board and Care that had not accepted the resident for admission, then was transferred to another Board and Care that was unaware of the resident going to their facility. This failure caused Resident 2 to have unnecessary transfer to the general acute care hospital.</p> <p>Findings:</p> <p>On March 27, 2024, at 10:43 a.m., an unannounced visit to the facility on a complaint investigation was initiated.</p> <p>A review of Resident 2's medical records indicated the resident was admitted on [DATE], and discharged on [DATE], with diagnoses of left shoulder osteoarthritis, (a progressive disorder of the joints caused by gradual loss of cartilage and resulting in the development of bony spurs and cysts at the margins of the joints), dehydration, (a harmful loss of the amount of water in the body), colitis, (a chronic inflammation of the inner lining of the colon), legal blindness, and dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>A review of Resident 2's History and Physical dated December 22, 2023, indicated he had the capacity to understand and make decisions.</p> <p>On March 27, 2024, at 2:17 p.m., an interview was conducted with the Social Service Director, (SSD). The SSD stated that Resident 2 was discharged to a board and care on March 25, 2024. The SSD stated that on March 25, 2024, she received a call from the transporter, informing her that the board and care (Board and Care 1) refused to accept the resident because he was male. The SSD stated that she called other board and cares in the area to find placement for Resident 2. The SSD stated that she spoke with an employee at a board and care facility (Board and Care 2), and they agreed to admit Resident 2 over the phone. The SSD stated that she emailed paperwork to the board and care (Board and Care 2) and provided the new address to the transporter. The SSD stated on March 26, 2024, she received a call from the social worker (SW) at the hospital, who informed her Resident 2 was at their facility. The SSD stated that she was informed by the SW that the resident was found outside of the board and care (Board and Care 2), and the board and care staff called 911. The SSD stated that they should have taken the resident back to the facility instead of finding another board and care. The SSD stated that Resident 2's family member and the Ombudsman were not notified of the new location.</p> <p>On March 27, 2024, at 4:48 p.m., an interview was conducted with the facility administrator (ADMIN). The ADMIN stated that he was aware of Resident 2's discharge. The ADMIN stated that Resident 2's discharge was not the normal protocol that they follow.</p> <p>On March 28, 2024, at 8:37 a.m., a telephone interview was conducted with the hospital's SW. The SW stated they received Resident 2 into the emergency roigom on [DATE]. The SW stated that the hospital staff called Resident 2's family member to find out where Resident 2 had been prior to being found outside the board and care.</p> <p>(continued on next page)</p>

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