

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2024
NAME OF PROVIDER OR SUPPLIER  Arbor Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  900 North Church Street Lodi, CA 95240	

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47369</p> <p>Based on interview and record review the facility failed to ensure a safe and effective transition of care after discharge from the facility for Resident 1 when Resident 1 was transferred to a room and board facility (where basic living needs are provided such as meals and housing) that was unable to provide for her care needs.</p> <p>This failure caused Resident 1 to be immediately transferred to the local emergency department from the room and board facility and to spend 26 days in the hospital pending appropriate placement. This failure further had the potential to negatively impact Resident 1 ' s health and psychosocial wellbeing.</p> <p>Findings:</p> <p>A review of Resident 1 ' s ADMISSION RECORD, indicated she was admitted to the facility in fall of 2022 with diagnoses which included morbid obesity (weight greater than 100 pounds over ideal body weight), repeated falls, and weakness.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section GG - Functional Abilities, dated 10/5/24, indicated, The code 02. Substantial/maximal assistance- Helper does MORE THAN HALF the effort. for the following care areas:</p> <p>Toileting hygiene: The ability to maintain perineal hygiene [wiping or cleaning after urination or a bowel movement], adjust clothes before or after voiding or having bowel movements</p> <p>Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self.</p> <p>Lower body dressing: The ability to dress and undress below the waist, including fasteners.</p> <p>Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility and,</p> <p>Tub/shower transfer: The ability to get in and out of a tub/shower.</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/24, at 3:02 PM, Certified Nurse Assistant (CNA) 1 stated she cared for Resident 1 prior to her leaving the facility. CNA 1 further stated Resident 1 needed a lot of assistance to get from her bed to her wheelchair, to use the bathroom, and to change her under garments because she was heavily incontinent of urine (little to no control of the bladder). CNA 1 stated Resident 1 was dependent for her showering needs, and required help to wash her hair, back, and legs.</p> <p>During an interview on 11/19/24, at 3:43 PM, licensed nurse (LN) 1 stated she cared for Resident 1 prior to her discharge. LN 1 further stated Resident 1 only got out of bed for activities. LN 1 stated Resident 1 was big and needed help. LN 1 further stated Resident 1 would sometimes walk to the bathroom, pushing the wheelchair, but she was very slow and had an unsteady gait, someone needed to be with her, it was scary, and she could not be alone.</p> <p>A review of Resident 1 ' s progress notes dated 9/5/24, at 10:17 AM, indicated Type: Social Services Business office and Administrator requesting (30) days notice for discharge due to non-payment .Called [room and board facility] and spoke with [owner] who can accept the pt [patient]. Safe location for pt. is located ABOM [ Assistant Business Office Manager] and SSD [Social Services Director] issued the (30) days notice to pt. Offered statement of Balance and copy of notice, she declined and stated My son is coming at noon today to make payment. Pt. decline to sign the Notice of Transfer or Discharge.</p> <p>A review of Resident 1 ' s PHYSICIAN PROGRESS NOTES, dated 10/1/24, indicated, Patient requires O2 [oxygen] @ 2 LPM [liters per minute] continuous due to dx. [diagnosis] of sleep apnea [disorder that causes breathing to stop or get very shallow] When patient exerts herself O2 level drops to 88%. (normal oxygen levels range between 95-100%) and Patient requires a bariatric wheelchair [wide] due to mobility limitations that significantly impairs ability to complete MRDLS [Mobility Related Activities of Daily Living, everyday activities that require movement and physical ability to perform] such as toileting, dressing, grooming, bathing.</p> <p>A review of a clinical document titled, [Facility Name] Notice of Transfer or Discharge, dated 10/5/24, indicated, Effective Transfer or discharge date [DATE] Planned Discharge Home or LLC [lower level of care] Enter Home or LLC Name, Address, &amp; Phone number [Room and Board facility name and address listed] The transfer/ discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by this facility.</p> <p>During a telephone interview on 11/19/24, at 2:07 PM, the Room and Board facility owner (RBO) stated Resident 1 never came into the facility. The RBO further stated, Resident 1 was dropped off and stated she could not move or get out of her wheelchair by herself. The RBO stated she had told the nursing home that she only takes residents who are independent for their care needs and the nursing home had told her that Resident 1 was independent and could take herself to the toilet. The RBO stated Resident 1 reported that she was unable to clean herself after using the toilet. The RBO informed Resident 1 that her facility did not provide that kind of service. The RBO stated Resident 1 indicated she was not told what type of facility she was being transferred to and that they had dumped her, then Resident 1 called 911.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/24, at 1:44 PM, the SSD stated Resident 1 was accepted to the Room and Board Facility with verbal details of her care needs. The SSD stated the accepting facility was told Resident 1 was ambulatory and needed toileting assistance. The SSD stated she did not hear anything from the room and board after they called 911. The SSD stated she had not been contacted by the hospital or the room and board facility.</p> <p>A review of Resident 1 ' s progress notes dated, 10/5/24, at 11:52 AM, indicated, Type: Social Services [SS] SS followed up with [Room &amp; Board facility] spoke with [owner] who confirmed pt. arrived safely! 5 mints [sic] later, received call from patient who stated [Room and Board Facility] is calling 911 they are unable to accommodate. Spoke with [owner] at [Room and Board Facility], informed her that she accepted patient with her ADL [Activities of Daily Living, activities related to personal care] status and patient care needs, and was made aware that facility pays for the first month rent \$1200. She stated calling 911 and sending patient to the hospital</p> <p>During a telephone interview on 11/20/24, at 8:49 AM, the hospital ' s Master of Social Worker (MSW) stated Resident 1 had been discharged from the nursing home to the Room and Board facility on 10/5/2024, when she arrived at the facility, Resident 1 was immediately deferred to the emergency department. The MSW further stated the room and board facility could not provide for Resident 1 ' s care needs and she was oxygen reliant and did not have any oxygen with her. The MSW stated, Resident 1 was assessed by physical therapy during her hospital stay and they determined she required short to long term care. The MSW stated she had conversations with social services at the nursing home about their failure to create a safe discharge plan for Resident 1 and they refused to take her back. The MSW further stated the Room and Board facility was for independent residents and there was no way Resident 1 was independent. The MSW further stated it was an inappropriate discharge. The MSW stated Resident 1 remained at the hospital until she was transferred to a skilled nursing facility in southern California on 10/31/24.</p> <p>A review of Resident 1 ' s [hospital name] Social Work Notes, dated 10/7/24, at 10:44 AM, indicated, Pt eval recom SNF [Physical therapy evaluation recommend skilled nursing facility]</p> <p>A review of Resident 1 ' s [Hospital Name] Social Work Notes, dated 10/8/24, at 10:28 AM, indicated, SW [social worker] consulted with SW Manager, who stated that [Facility Name] needs to take pt back due to failed discharge plan. SW called [Facility Name] .notified that it was failed DC [discharge] and not safe DC so want to discuss [Facility Name] taking pt back and making safe DC plan .[Admissions Coordinator] stated the Administrator .issued the request for DC due to pt not paying her SOC [share of cost, amount of money person is responsible to pay towards their medical services] and that administrator stated that pt does not meet the requirement for SNF and didn ' t need that level and pt not paying her bills .SW stated that it was not a safe discharge to [Room and Board facility] as they sent pt to ED [emergency department] after she got there due to not being able to care for pt and not having O2. SW stated they believes [sic] that [facility name] should take pt back and do safe DC.</p> <p>During an interview on 11/19/24, at 3:43 PM, the Administrator (ADM) stated when residents are transferred to other facilities, the facilities are sent information regarding their needs as requested, or the accepting facility will come in to assess the resident before transfer. The ADM further stated there was a disconnect with Resident 1 ' s transfer and she was not sure what caused it.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy titled, ADMISSION, TRANSFER, DISCHARGE AND BED-HOLDS, dated December 2016, indicated, PURPOSE To promote equal access to quality care and facilitate continuity with care transitions. The facility will provide sufficient preparation and orientation to residents and resident representatives in order to ensure a safe and orderly discharge from the facility.</p> <p>An online review of the Room and Board business name at the address provided did not yield any results, photos of the address of the room and board facility, accessed on 11/21/24, at <a href="https://www.homes.com/property/501-s-pershing-ave-stockton-ca/04kr3n5xyef44/copyright%202024">https://www.homes.com/property/501-s-pershing-ave-stockton-ca/04kr3n5xyef44/copyright 2024</a>, indicated, a home in a residential area with multiple external doorways that were not wheelchair accessible. All the doorways viewed required at least one step up to enter.</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47369</p> <p>Based on interview and record review the facility failed to readmit Resident 1 when she was transferred to a local emergency department after an unsafe discharge to a room and board facility (where basic living needs are provided such as meals and housing) that could not accommodate her care needs.</p> <p>This failure put Resident 1 at risk of psychosocial harm and negative health outcomes.</p> <p>Findings:</p> <p>A review of Resident 1 ' s ADMISSION RECORD, indicated she was admitted to the facility in fall of 2022 with diagnoses which included morbid obesity (weight greater than 100 pounds over ideal body weight), repeated falls, and weakness.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section GG - Functional Abilities, dated 10/5/24, indicated, The code 02. Substantial/maximal assistance- Helper does MORE THAN HALF the effort for the following care areas:</p> <p>Toileting hygiene: The ability to maintain perineal hygiene [wiping or cleaning after urination or a bowel movement], adjust clothes before or after voiding or having bowel movements.</p> <p>Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self.</p> <p>Lower body dressing: The ability to dress and undress below the waist, including fasteners.</p> <p>Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility and,</p> <p>Tub/shower transfer: The ability to get in and out of a tub/shower.</p> <p>A review of a clinical document titled, [Facility Name] Notice of Transfer or Discharge, dated 10/5/24, indicated, Effective Transfer or discharge date [DATE] Planned Discharge Home or LLC [lower level of care] Enter Home or LLC Name, Address, &amp; Phone number [Room and Board facility name and address listed] The transfer/ discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by this facility.</p> <p>(continued on next page)</p>		

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