

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Citrus Heights Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7807 Uplands Way Citrus Heights, CA 95610	

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>Based on interview and record review, the facility failed to ensure required documentation for discharge was present in the medical record for one of four sampled residents (Resident 1), when there was no physician order indicating the basis of Resident 1 ' s discharge, there was no discharge summary, and there was no notice of discharge in Resident 1 ' s medical record.</p> <p>This failure had the potential for delay in Resident 1 ' s care after discharge.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission records, the records indicated Resident 1 was admitted to the facility in May 2025 with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), and local infection of the skin and subcutaneous tissue (under the skin). Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 1 had intact cognition.</p> <p>During a review of Resident 1 ' s case management progress notes, dated 5/29/25, the notes indicated, . [Resident 1] verbalized she is refusing care by our provider rt [related to] a self-proclaimed lawsuit. This nurse offered to have her sent back to acute to have alternate placement. [Resident 1] verbalizes she agrees with transfer .</p> <p>During a review of Resident 1 ' s nurse progress notes, dated 5/29/25, the notes indicated, .[Resident 1] discharged to [name of hospital] due to conflict of interest .</p> <p>During a review of the intake information received by the Department, dated 5/30/25, the information indicated, .when [name of NP &ndash; nurse practitioner] seen [Resident 1], [NP] said, there would be someone else that could tend to [Resident 1] .[Staff] came to [Resident 1] and told [Resident 1] that [Resident 1] had to leave, that there was a conflict of interest and the facility kicked [Resident 1] out .</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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/4/25 at 11:44 a.m. with the Case Manager (CM), the CM stated the NP came to see Resident 1 and they recognized each other. The CM further stated that according to Resident 1, Resident 1 had a lawsuit with the NP and the NP realized the conflict of interest. The CM stated, .We offered to send [Resident 1] to [the hospital] .[Resident 1] agreed to have alternate placement arranged because of the conflict of interest . The CM reviewed Resident 1 ' s medical record and stated, .I don ' t think [NP] wrote the order [for discharge] because the resident refused our provider .I don ' t believe an order was written before and after [Resident 1] left .</p> <p>During an interview on 6/4/25 at 12:32 p.m. with the Social Services Director (SSD), the SSD stated, .For all discharges, there has to be an order before they go, otherwise it ' s against medical advice (AMA &ndash; when a resident leaves before the medical team recommends discharge) .The doctor also write the discharge summary .Notice of proposed transfer or discharge should also be completed for planned, unplanned, or even AMA discharges .The resident is supposed to sign it and to be sent to the Ombudsman .</p> <p>During a concurrent interview on 6/4/25 at 12:46 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, .There should be an order from the doctor for discharge .As soon as the resident left, I write the discharge summary .Important because that ' s the recap of the resident ' s stay in the facility and the plan for their discharge . The ADON confirmed there was no order for discharge, no discharge summary, and no notice of the proposed discharge in Resident 1 ' s medical records.</p> <p>During an interview on 6/4/25 at 1:07 p.m. with the Medical Records Director (MRD), the MRD stated, The nurses complete the notice of proposed discharge .It is for all discharges .I expect that this form was completed once the resident got discharged .To make sure that we are doing the correct discharge/transfer, that everything is done correctly and steps are completed correctly .</p> <p>During an interview on 6/4/25 at 1:16 p.m. with the Director of Nursing (DON), the DON stated, .I don ' t think there was an order because the doctor doesn ' t get involved with [Resident 1] .There should be notes from the NP at that time when the resident refused the care .There should be one completed on the nurses side so people are aware why [Resident 1] left .</p> <p>During an interview on 6/4/25 at 2:30 p.m. with the NP, the NP stated, When [Resident 1] got here [the facility], I recognized [Resident 1] name .I went to her room to do her assessment .[Resident 1] was being seen by wound nurse .I came back later .and before I saw the resident again, the wound nurse told me about the lawsuit .I confirmed with the resident that I was part of the lawsuit .I told the resident that [Medical Director] will be following up with the resident and [Resident 1] said okay .At some point, I was informed that she will be sent back to the hospital for alternate placement .I didn ' t document that I told the resident that [Medical Director] will be taking over because [Medical Director] was my supervising physician .I told him right away and he was aware of it .For discharge, there must be signed discharge orders .</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/4/25 at 2:52 p.m. with the Administrator (ADM), the ADM stated, "[NP] went to do assessment and [Resident 1] recognized her. The resident confirmed NP was part of the case. It's a conflict. We were calling to arrange [Resident 1] to go back to the referring hospital. We got the okay from the hospital to send her back. We didn't have a physician for her so we have to do it. I don't know if [NP] talked to [MD]. I didn't talk to [MD]. [MD] is part of the physician group with the lawsuit. It would be hard for [MD] to give that order. As the administrator, I decided to communicate with the hospital to see if they will accept [Resident 1] back. The Administrator confirmed there were no physician order for Resident 1's discharge, no discharge summary, and no notice of proposed discharge in Resident 1's medical records.</p> <p>During a review of the facility's policy and procedure (P&P) titled Transfer or Discharge, dated 3/2025, the P&P indicated, .1. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: a. The basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or legal representative; .f. A summary of the resident's overall medical, physical, and mental condition .</p> <p>During a review of the facility's P&P titled Discharging a Resident Without a Physician's Approval, revised 3/2025, the P&P indicated, A physician's or provider's order is obtained for discharges, unless a resident or representative requests the discharge against medical advice .1. An order of an approved discharge must be signed and dated by the physician or provider and recorded in the resident's medical record no later than seventy-two (72) hours after the discharge .5. Regardless of the resident or representative's request to leave the facility against medical advice, the facility will provide a Notice of Discharge, discharge orientation, and a Discharge Summary .before the resident leaves the facility .</p>