STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwood Health Care	5320 Carrington Circle Stockton, CA 95210

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49823 Based on interview and record review, the facility failed to provide written notice of a facility-initiated discharge (notice given to resident to find another place to live in 30 days ' time) for one of one sampled residents (Resident 2) when, Resident 2 ' s Responsible Party (RP, a designated person to make decisions for another person) was verbally notified of Resident 2 ' s discharge from the facility on 9/5/24, however a written notice of discharge document was not sent/given to Resident 2's RP. This failure resulted in Resident 2's RP being uninformed of how to appeal the decision of a facility-initiated discharge and removed the opportunity for Resident 2's RP and/or the ombudsman (advocate for residents) to advocate on Resident 2's behalf. Findings: During an interview by phone with Resident 2 ' s RP on 9/23/24 at 12:40 p.m., the RP stated that the facility staff called her and verbally informed her that Resident 2 was sent to the hospital by ambulance on 9/5/24. The RP stated that the facility also told her that Resident 2 was discharged from the facility at that time. The RP stated that the facility staff stated that they did not want Resident 2 to come back to the facility. During an interview on 11/18/24, at 3:19 p.m., with Resident 2's RP, the RP stated a written discharge notice was not provided to her by the facility when Resident 2 was discharged from the facility to the hospital. The RP stated, the facility did not inform her of the appeal rights, how to file an appeal if she disagreed with the discharge decision and contact information for the appeal unit and the ombudsman. The RP stated she first learned about the appeal rights and process from a hospital social worker. During an interview with the facility Administrator (ADM) on 9/23/24 at 3:10 p.m., the ADM acknowledged that a written 30-day notice of discharge document was not sent to Resident 2's RP. The ADM confirmed that there was no documentation in Resident 2 ' s electronic medical record (EMR) that a written transfer/discharge notice was provided. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24, at 12:22 p.m., the ADM stated Resident 2 was sent to the hospital and discharged from the facility on 9/5/24 due to Resident 2's psychotic episodes (a period of time when a person's thoughts and perceptions are disrupted, making it difficult to distinguish reality from what's not real). The ADM stated a verbal notice of discharge was provided to Resident 2's RP and not to Resident 2 himself because he was developmentally delayed. Review of Resident 2's [Facility Name] NOTICE OF TRANSFER / DISCHARGE, dated 9/5/24, indicated, Notification Date: 9/5/24 Person Notified: [Resident 1's RP name listed] Effective Date: 9/5/24. This notice is to notify you of the transfer/discharge is necessary for the following reasons. The transfer or discharge was necessary for your welfare and your needs cannot be met in the facility [was checked] A review of a facility policy and procedure (P&P) titled, Transfer or Discharge Documentation, revised January 2019, the P&P indicated, 4. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record b. That an appropriate notice was provided to the resident and/or legal representative. Review of an All Facilities Letter titled, Transfer, Discharge and Readmission Requirements, dated 1/20/16, indicated, Notice Provided to Resident Prior to Transfer or Discharge Before any transfer or discharge occurs, the facility must notify, in writing, the resident and, if known, the family member or legal representative of the transfer or discharge and the reasons for the move. The reasons for the move must be recorded in the resident ' s clinical record. This notice must be made by the facility at least 30 days before the resident is transferred or discharged unless the transfer is made for medical, health and safety reasons, or in cases of facility closure. (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-16-01.aspx) Review of the Department of Health Care Services (DHCS) undated webpage titled Transfer Discharge and Refusal to Readmit Unit, indicated, The Office of Administrative Hearings and Appeals (OAHA) is responsible for adjudicating appeals of residents who face a facility-initiated transfer or discharge from their nursing facility, or whose nursing facility has refused to readmit the resident following a period of hospitalization or therapeutic leave. Transfer or Discharge Appeals (TDA) Under federal and state law, when a nursing facility initiates the transfer or discharge of a nursing home resident, the resident has established rights that must be addressed in order to ensure that the discharge is fair and appropriate. An essential component to these rights is the right to request a hearing. Only the resident or a resident's authorized representative may request a transfer/discharge hearing. Residents desiring a hearing should submit a request as soon as possible in order for a decision in the matter to be rendered before the proposed date of discharge. (https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Transfer-Discharge-and-Refusal-to-Readmit-Unit.aspx)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to determine if one of one sampled resident (Resident 2) could return to the facility following a transfer to an acute care hospital from the facility when, Resident 2 was sent to an acute care hospital on 9/5/24 from the facility and not allowed to return; 1. There was no documented evidence that the facility communicated with the hospital (communication with the hospital and nursing home staff and/or via visits to the acute care hospital to assess the resident ' s condition) to determine an accurate status of Resident 2 ' s condition at the time the acute care hospital attempted to discharge Resident 2 back to the facility; and 2. There was no documented evidence that the facility attempted to communicate with the acute care hospital the needs of Resident 2 to return to the facility (treatments, medications, and/or services) to determine if the facility could meet those needs or not. These failures had the potential to negatively impact Resident 2 ' s psychosocial well-being. Findings: A review of Resident 2 ' s ADMISSION RECORD indicated that Resident 2 was admitted to the facility with diagnosis including heart failure (a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living), and anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks, and interfere with daily living). During an interview by phone with Resident 2 ' s Responsible Party (RP, family member) on 9/23/24 at 12:40 p.m., the RP stated that the facility staff called her and verbally informed her that Resident 2 was sent to the hospital by ambulance on a 5150 (5150 is the number of the section of the Welfare and Institutions Code, which allows an adult who is experiencing a mental health crisis to be involuntarily [done against someone ' s will] detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled [a condition in which a person, as a result of a mental disorder, is unable to provide for his or her needs]) on 9/5/24. The RP stated that the facility told her that Resident 2 was discharged from the facility. The RP stated that the facility staff stated that they did not want Resident 2 to come back to the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2 ' s SBAR [Situation-Background-Assessment-Recommendation] Summary for Providers, dated 9/5/24, indicated, At 0930 [9:30 AM], resident was spoken to by SSD [Social Services Director] regarding room change. Resident began being verbally aggressive towards SSD. SSD got CM [case manager] to attempt speaking to resident about room change. Resident began being verbally aggressive towards CM. ADON [assistant director of nursing] brought into room to deescalate situation. Resulted in resident grabbing leg rest and throwing it, hitting ADON ' s right lower arm. MD [Medical Doctor] made aware of situation at 0940 [9:40 AM]. SSD called 911 for physical aggression towards staff for safety concerns. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback. Recommendations: Recommend to send patient out for 5150. During an interview by phone with the facility Social Service Director (SSD), Social Services Assistant (SSA), and Case Manager (CM) on 9/24/24 at 11:02 a.m., the SSD stated that she was not sure if anyone from the facility went to the acute care facility since Resident 2 was admitted on [DATE] to reassess Resident 2 to see if Resident 2 was unfit to return to the facility. The CM stated that the last time Resident 2 was seen and assessed by anyone at the facility was on 9/5/24 by a licensed nurse. During an interview by phone with Resident 2 ' s primary physician (Medical Doctor) at the facility on 9/25/24 at 11:35 a.m., the MD stated that neither he nor anyone at the facility had been to the acute care facility to assess Resident 2 ' s readiness to return to the facility. Review of a hospital note for Resident 2 titled Case Management Note, dated 9/10/24, indicated, called [name of long-term care facility] to confirm bed hold. Admissions transferred me to Nursing dept [department] and spoke to the MD [medical doctor]. He feels [Resident 2] will be more appropriate at [name of behavioral health skilled nursing home]. Review of a hospital note for Resident 2 titled Case Management Note, dated 9/10/24, indicated, called [name of long-term care facility] and spoke with [Administrators (ADM) name]. He informed me that the patient was discharged from their facility on 9/5/2024 and they will not accept the patient back. Review of a hospital note for Resident 2 titled Case Management Note, dated 9/12/24, indicated, this [writer] spoke with Admin [Administrator] and DON [Director of Nursing] of said SNF [skilled nursing facility] by phone who informed this Clinician that after speaking with the attending Physician, the pt ' s [patients] bx [behavioral diagnosis] is acute, therefore, the pt can no longer be treated at their facility and would be best served in a locked facility. [Writer] inquired with [name of SNF ADM] if a MED-EVAL [evaluation of the residents current medications to identify any actual or potential medication-related problems and recommendations to optimize medicine use in accordance with the treatment plan] was completed, while the pt was at their facility, to perhaps incorporate mood stabilizers [Medications used in the treatment of bipolar disorder, where a person's mood changes from a depressed feeling to a high manic feeling or vice versa. These drugs can help reduce mood swings and prevent manic and depressive episodes] to help minimize behavioral disturbances. [SNF ADM name], did not respond to this Clinician ' s question re [regarding]: MED-EVAL stating that based on the physician ' s recs [recommendations], they are no longer able to accommodate the pt at their facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a hospital note for Resident 2 titled Case Management Note, dated 9/20/24, indicated, Prior to admissions [Resident 1] has been a long term care resident [name of long term care facility]. [Resident 2] was sent here when he injured a nurse. Call placed to admissions at [name of long-term care facility] Goal is to discharge him back to his LTC facility. [Resident 2] has been cleared by County Mental Health. Review of a facility Policy and Procedure titled TRANSFER OR DISCHARGE DOCUMENTATION, revised 1/19, indicated, When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless- a. The transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in this facility. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident ' s clinical record by the resident ' s Attending Physician: a. The transfer or discharge is necessary for the resident ' s welfare, and the resident ' s needs cannot be met in the facility. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met; (b) this facility ' s attempt to meet those needs; and (c) the receiving facility ' s service(s) that are available to meet those needs.