STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an effective discharge planning process for one of 3 Residents (Resident 1) when Resident 1 who was homeless was discharged without proper arrangements for home health nursing services to manage multiple burn wounds, food, or transportation to follow up medical appointments. A review of the admission record indicated the facility admitted Resident 1 in the fall of 2025 with multiple diagnoses which included aftercare for multiple burn wounds that had been surgically grafted (a procedure where healthy skin is taken from one part of the body and transplanted to cover another area where skin is damaged). Resident 1's medical history indicated Resident 1 had third degree burns over 20-29% of her body surface area, muscle wasting and atrophy, gait and mobility disorders, and a carrier of Methicillin Resistant Staph Aureus (MRSA- a type of bacteria that becomes resistant to common antibiotics).A review of a document titled Order Summary Report dated 12/8/2025 , with the current physician's orders indicated Tx: (Treatment) generalized burn wound to lower bac (sic) cleanse with NS (Normal Saline), pat dry, apply mupirocin cream 2% (medicated ointment) and cover with dry dressing QD (daily) and PRN (as needed) for dislodgement until resolved, and, Tx: healed burn wounds apply Eucerin lotion (lotion used to moisten the skin) and leave open to air BID (two times per day).During an interview on 12/9/2025 at 9:15 a.m., the Case Manager/ Social Worker (CM/SW) stated her responsibility in the process of resident discharge is to ensure a safe discharge to home or another suitable place. The CM/SW stated she had not made an attempt to reach out to homeless shelters or home health agencies to provide follow up care for Resident 1's planned discharge. Further discussion as to why Resident 1 was being discharged , the CM/SW stated Resident 1 went in and out of the facility too often and stated It is Medi-Cal fraud for her to stay in the facility. The CM/SW acknowledged Resident 1 followed the facility policies for leaving the property to smoke and returned as expected. CM/SW stated she had not advised Resident 1 of the right to appeal the discharge.During an interview on 12/9/2025 at 9:55 a.m., with Resident 1 in Resident 1's room in the presence of the Ombudsman and CM/SW, Resident 1 stated she was homeless due to a fire when she was burned, which destroyed her home. Resident 1stated she was advised by the CM/SW on 12/8/2025 at approximately 3:30 p.m., that she would be discharged the next day (12/9/2025). Resident 1 stated when she questioned why she was being discharged she was told by the CM/SW You are committing Medi-Cal fraud by staying here. Resident 1 further stated she could not care for herself as she had burns on her back, legs and arms as well as open blisters on both upper legs that needed medicated ointment applied that she is not able to apply herself. Resident 1 stated she did not have a relationship with family who could help care for or house her. Resident 1 stated she had not received written discharge instructions or information for follow- up care. Resident 1 confirmed only receiving the verbal instructions from the CM/SW that she would be discharged on 12/9/2025 and that she could leave whenever she could get a ride. During an interview on 12/9/2025 at 10:24 a.m., with the Director of Nursing (DON) in the presence of the CM/SW, DON stated she believed Resident 1's discharge was safe and appropriate. DON stated Resident 1 was being discharged because She comes and goes too often from the facility. DON stated Resident 1 followed the facility policy and had physician's order to leave the facility for no specified amount of time or frequency. DON stated, Resident 1 signed in the book (used to track leaves of absence) what time she went out and when she returned. DON indicated she was not aware if discharge planning had been completed for Resident 1. During an interview on 12/9/2025 at 11:15 a.m., with the Administrator (ADM), DON and CM/SW, the ADM stated on 12/8/2025 in the morning he had driven to a motel in Sacramento and had spoken to the front desk clerk who indicated the motel would have a room available for Resident 1. ADM stated he did not make a reservation to hold a room for Resident 1, nor did he have any idea how Resident 1 would obtain food or care for herself since home health nor any other organization had been contacted to provide food or nursing to care for Resident 1's burn wounds. Further discussion with ADM, he stated he intended to pay for a three night stay at the motel then had no plan nor idea as to where Resident 1 would go for shelter or burn care when those three days were over. The ADM stated he did not document the information in a discharge plan or medical record and did not discuss the plan with Resident 1. During an interview on 12/9/2025 at approximately 11:30 a.m., with the Wound Nurse (WN) in the presence of the ADM and CM/SW, the WN stated Resident 1 had two open wounds on her right upper leg and three open wounds on her left upper leg. WN stated she had not measured the open wounds but felt Resident 1