STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Post-Acute	1617 Ramirez Street Marysville, CA 95901

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46527 Based on interview and record review the facility failed to ensure one of three residents sampled for patient rights (Resident 1) was treated with dignity and respect when the Marketing Director (MD) had spoken with Resident 1 on the phone with the hospice nurse (HN) available and stated, What the hell are you doing. We would've never brought you back if we knew you weren't going on hospice. Nobody wants you here, This resulted in Resident 1 becoming tearful and had the potential to result in psychosocial harm. Findings: A review of a facility policy titled, Resident Rights, with a revised date of [DATE], indicated, Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. A review of the facility's records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems), obstructive sleep apnea (sleep disorder with recurrent episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing), other abnormalities of gait and mobility, generalized muscle weakness, acquired absence of right leg above knee, chronic pain syndrome, and unspecified depression (symptoms of depression). During an interview on [DATE] at 2:45 PM with Resident 1's power of attorney (POA), she stated the Marketing Director (MD) had spoken with Resident 1 on the phone with the hospice nurse (HN) available and stated, What the hell are you doing. We would've never brought you back if we knew you weren't going on hospice. Nobody wants you here, which caused Resident 1 to cry. POA stated that after speaking to Resident 1 he stated he did not have a POLST filled out but did not want to die, but did not want full Cardiopulmonary Resuscitation (CPR), so he had picked selective treatment. She stated that she requested for a POLST form and was met with comments that stated Resident 1 is supposed to go onto hospice, and he would not need a POLST. POA stated that once Resident 1 was sent to the hospital on [DATE] at 5:50 AM, the facility informed POA that Resident 1 had his POLST sent to the hospital with him; however, upon arrival to the hospital she found Resident 1 intubated and being transferred to the ICU. POA stated, How is it that days later they didn't have that signature on the POLST. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:30 PM with the hospice liaison (HL), she stated the MD was on the phone with Resident 1 and stated, The only reason I brought you back was because you said you were going to go on hospice, and further stated that the hospice staff took the phone away from Resident 1 because it was not okay to speak with him that way. HL stated after she spoke with Resident 1 he did agree to hospice after a consult, but did not want to start hospice at the facility because he did not feel safe, we then updated his POLST. HL stated the POLST was never signed by his provider, and he had a medical emergency that resulted in CPR and being intubated. HL stated that the staff was not helpful and unprofessional and initially refused to give him a POLST to fill out and stated he needs to go on hospice and not deal with a POLST. During an interview on [DATE] at 11:45 AM with Licensed Vocational Nurse (LVN) 1, she stated the, POLST was not signed, by the medical provider, but it was signed by the resident as DNR selective. It wasn't signed on the 20th, and stated how she has expressed her concerns to the medical provider. LVN 1 stated the EMT's that arrived said Resident 1 will be considered full code (full resuscitation attempt) due to the POLST not being signed by the medical provider. LVN 1 stated, Yes, they should, sign the POLST immediately in some form, especially since Resident 1 had been declining. LVN 1 stated there was a lack in the quality of care for Resident 1. During an interview on [DATE] at 12:15 PM with MD, stated Resident 1 was supposed to be admitted to hospice; however, according to them (the hospice nurse) determined that he was alert and oriented (of sound mind) and he refused hospice at that time. MD, who confirmed she was a marketer with no medical background, stated when she talked to him he seemed confused and not oriented. MD stated she felt that Resident 1 needed hospice even though he was of sound mind at the time he refused hospice care. MD stated she was talking to the hospice nurse over the phone on speaker with Resident 1 present and stated that he was supposed to be on hospice as it was the plan and she did not want hospice to leave without him signing up for hospice. MD stated she was upset that hospice left and didn't follow through with Resident 1 and she did not feel that hospice offered all that they were supposed to offer him. During an interview on [DATE] at 1:25 PM with Director of Nursing (DON), she stated that the resident had a right to determine he did not want to go on hospice as he was oriented, which she had also verified. DON stated that someone without a medical background should not be able to determine if a resident was confused and not oriented.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46527 Based on interview, and record review, the facility failed to implement resident-directed care consistent preferences and rights for one of three residents sampled for patient rights (Resident 1) when the facility did not maintain a valid copy of Physician Orders for Life-Sustaining Treatment (POLST- a voluntary option for people to use to communicate their end-of-life decisions) in Resident 1's medical record when transfer from the facility via ambulance was made. This failure resulted in Resident 1's right to decline specific treatment in the event of a medical emergency to not be followed. Findings: A review of a facility policy titled Advance Directives, with a revised date of [DATE], indicated, The director of nursing services or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care . The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive . The nurse supervisor is required to inform emergency medical personnel of a residents advance directive regarding treatment options and provide such personnel with a copy of the advance directive or Physician orders for life-sustaining treatment (POLST) when transfer from the facility via ambulance or other means is made. A review of a facility policy titled, Resident Rights, with a revised date of [DATE], indicated, Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. A review of a facility policy titled, Do Not Resuscitate Order, with a revised date of [DATE], indicated, Do not resuscitate (DNR, allow natural death) orders must be signed by the resident's attending physician . State specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include: POLST . A review of the facility's records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems), obstructive sleep apnea (sleep disorder with recurrent episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing), other abnormalities of gait and mobility, generalized muscle weakness, acquired absence of right leg above knee, chronic pain syndrome, and unspecified depression (symptoms of depression). A review of the facility's record POLST for Resident 1 indicated selective treatment (do not intubate, avoid intensive care (ICU), comfort-focused care) was selected for Resident 1 with a DNR. The date the form was prepared was on [DATE], and it was signed by Resident 1 on [DATE]. This form indicated that the Physician (DR) signed the POLST on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's progress note dated [DATE] at 7:51 AM, indicated, Resident was sent with face sheet, medication summary, and POLST of DNR selective however it had pending provider's signature of DNR elective. Emergency Medical Technician (EMT) stated, provider's signature is required, therefore resident is considered full code. He left the facility . at 0550. POA was notified at 5:54 AM. A review of the facility's calendar for the physician and nurse practitioner schedule for [DATE], indicated, the nurse practitioner and physician did not enter the clinic to see residents [DATE]th, 18th, 19th of 2025. The nurse practitioner did enter the clinic to see residents on [DATE] and the physician did not enter the clinic until [DATE]. During an interview on [DATE] at 2:45 PM with Resident 1's power of attorney (POA), she stated the Marketing Director (MD) had spoke with Resident 1 on the phone with the hospice nurse (HN) available and stated, What the hell are you doing. We would've never brought you back if we knew you weren't going on hospice. Nobody wants you here, which caused Resident 1 to cry. POA stated that after speaking to Resident 1 he stated he did not have a POLST filled out but did not want to die, but did not want full Cardiopulmonary Resuscitation (CPR), so he had picked selective treatment. She stated that she requested for a POLST form and was met with comments that stated Resident 1 is supposed to go onto hospice, and he would not need a POLST. POA stated that once Resident 1 was sent to the hospital on [DATE] at 5:50 AM, the facility informed POA that Resident 1 had his POLST sent to the hospital with him; however, upon arrival to the hospital she found Resident 1 intubated and being transferred to the ICU. POA stated, How is it that days later they didn't have that signature on the POLST. During an interview on [DATE] at 11:45 AM with Licensed Vocational Nurse (LVN) 1, she stated the, POLST was not signed, by the medical provider, but it was signed by the resident as DNR selective. It wasn't signed on the 20th, and stated how she has expressed her concerns to the medical provider. LVN 1 stated the EMT's that arrived said Resident 1 will be considered full code (full resuscitation attempt) due to the POLST not being signed by the medical provider. LVN 1 stated, Yes, they should, sign the POLST immediately in some form, especially since Resident 1 had been declining. LVN 1 stated there was a lack in the quality of care for Resident 1. During an interview on [DATE] at 1:25 PM with Director of Nursing (DON), she stated, No, it wasn't appropriate, for the physician to sign the POLST with a date of [DATE] when they were not there to sign it that day and stated that nobody should be backdating documentation. DON stated it is not fair that the resident had to be intubated (to insert a tube for breathing) if he did not want to be intubated.