

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Morgan Hill Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 530 West Dunne Avenue & LA Selva Morgan Hill, CA 95037	

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 - 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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<p>F 0627</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their discharge policy for one of three sampled residents (Resident 1) when Resident 1 was not allowed to return to the facility after a doctor's appointment. This failure had the potential to compromise Resident 1's health and safety. Review of Resident 1's clinical record titled, admission Record, dated 12/5/2025, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), cerebrovascular disease (CVA-stroke, loss of blood flow to a part of the brain), hypertension (HTN-high blood pressure), other amnesia (loss of memories, including facts, information, and experiences), and alcohol dependence, uncomplicated (a chronic disease in which a person craves drinks that contain alcohol and is unable to control his or her drinking). Review of Resident 1's Nurses Progress Note dated 12/4/2025, indicated, Resident left facility without out on pass at 13:30 [1:30 PM]. Resident reported to this nurse that he had an appointment with a PCP [primary care physician] outside of the facility. Informed social services. Resident went out of facility without an order from MD [medical doctor]. During an interview with the nurse practitioner (NP) on 12/5/2025 at 1:18 a.m., the NP confirmed she received a message from their group chat on 12/4/2025 at 6:37 p.m., it indicated, patient left AMA [against medical advice] around 2 p.m. NP further confirmed she did not respond to the message because it was already after hours. NP stated nurses should have notified the after hour on-call physician or NP. During a phone interview with licensed vocational nurse A (LVN A) on 12/5/2025 at 1:48 p.m., LVN A confirmed he was the nurse in the evening shift on 12/4/2025. LVN A stated their social services director (SSD) instructed them not to allow Resident 1 back to the facility, and to call 911 to accept him back to the facility. LVN A further stated, Resident 1 was in a cab when he came back around 6:00 p.m. on 12/4/2025, and he was on the phone talking to his sister. LVN A confirmed he did not ask Resident 1 to come back inside the facility, he did not call the DON and their doctor about the situation. LVN A further confirmed he just followed the SSD's instruction not to accept Resident 1 back to the facility and he went back inside the facility to continue with passing medications to his residents. During an interview with certified nursing assistant B (CNA B) on 12/5/2025 at 2:13 p.m., CNA B confirmed their SSD informed the evening staff that Resident 1 left AMA, she did not go to full details, and instructed them not to allow Resident 1 back to the facility. CNA B stated the SSD handed her the AMA form to provide to Resident 1 if he comes back. CNA B further stated, Resident 1 came back on the same day at around 5:30 p.m., she handed him the AMA form, and Resident 1 told her that he had nowhere to go. CNA B stated Resident 1 was upset, obviously in disbelief because he just went out to an eye doctor's appointment. CNA B further stated Resident 1's sister called the police, and the police called the paramedics to send Resident 1 to the hospital. CNA B confirmed Resident 1 was outside the facility for at least an hour. During an interview with the SSD on 12/5/2025 at 2:29 p.m., the SSD stated she overheard from staff that Resident 1 went out for an appointment. The SSD further stated, she checked her calendar and Resident 1's physician order and it indicated there was no doctor's appointment scheduled for the day and there was no order that Resident 1 could go out on pass. SSD stated she called her consultant, and she was advised that Resident 1 went AMA. SSD confirmed she initiated Resident 1's AMA form and she instructed the evening shift staff not to accept Resident 1 back to the facility. SSD further confirmed that there was no physician's order related to Resident 1's AMA discharge and she was just following the AMA situation. During a concurrent interview with the director of nursing (DON) and record review of Resident 1's nurses progress notes dated 12/4/2025, and order summary report on 12/5/2025 at 3:08 p.m., the DON confirmed there was no documentation that the doctor was notified about Resident 1's return and the SSD was the only one notified. The DON further confirmed there was no AMA order. The DON stated she was only notified in the morning of 12/5/2025 that Resident 1 came back and was brought to the hospital. During an interview with the administrator (ADM) on 12/5/2025 at 3:34 p.m., the ADM stated the nurse should have allowed Resident 1 back to the facility, did their assessment, and if Resident 1 needed to be transferred to the hospital, they should have called the doctor and transferred him as needed. Review of the emergency department's (ED) provider note dated 12/4/2025, indicated, 70 y.o. [year old] male. brought to the ED by EMS [emergency medical services] after patient was discharged from his nursing home - [name of the facility]. Reportedly patient has been a resident there for 4 months went to his scheduled ophthalmology eye doctor appointment and when he returned his</p>		