| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555736 | A. Building<br>B. Wing | 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Sonora Care Center | 19929 Greenley Road<br>Sonora, CA 95370 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44260<br><br>Based on interview, and record review, the facility failed to ensure the right to return to the facility was protected for one of one sampled resident (Resident 1), when:<br><br>1. Resident 1 was sent to the hospital and was not allowed to return to the facility on [DATE],<br><br>2. A facility physician did not document a basis for Resident 1's discharge; and,<br><br>3. The facility failed to provide a written Notice of Transfer or Discharge to Resident 1, Resident 1's representative (RP), and the Long-Term Care (LTC) Ombudsman (a patient rights advocate).<br><br>These failures placed Resident 1 at risk for emotional distress, removed the opportunity for the State LTC Ombudsman to advocate on Resident 1's behalf, and deprived Resident 1 or his RP of information regarding rights to appeal the transfer/discharge.<br><br>Findings:<br><br>1. Review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in 2024 with diagnoses including prostate cancer and secondary malignant neoplasm of brain (cancer cells spreading to the brain from another part of the body).<br><br>Review of Resident 1's hospital record, Behavioral Health Consultation, dated 6/7/24, at 2:53 p.m., indicated, .He has been calm and cooperative in the ED for approximately 8.5 hours. The patient does not have a mental health diagnosis which would be responsible for his symptoms .would not benefit from inpatient psychiatric hospitalization . Patient's behavior likely in the context of medication non-compliance and medical co-morbidities. Discussed r/b/a [risks, benefits and alternatives] of treatment options with the patient and his brother who were agreeable to receiving [name of psychotropic medication] and returning to the SNF [skilled nursing facility] .<br><br>Review of Resident 1's electronic health record (EHR) titled, Progress Notes, dated 6/7/24, at 6:40 p.m., indicated, .RP .contacted via phone by this nurse r/t [related to] [Resident 1] being sent back to [Hospital] . This nurse informed [RP] that [Resident 1] had been sent back to acute care r/t aggressive behaviors .<br><br>(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 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 1's hospital record, Emergency Department Reports, dated 6/7/24, at 6:49 p.m., the History section indicated, .BIBA [brought in by ambulance] from [name of facility] per .staff request. Pt [patient] was in ED [emergency department] earlier today for agitation .later released by behavioral health. Pt currently on hospice [care provided at end of life] for metastatic CA [cancer which has spread] with mets [metastases-sites of spread to other areas of the body] to the brain .his hospice team was contacted earlier today from ED regarding medication management and medication changes to keep him more comfortable and to decrease his agitation and pt was discharged back to [facility name] this afternoon. On my evaluation patient has no complaints .<br><br>Review of Resident 1's hospital record, Emergency Department Reports, dated 6/7/24, at 6:49 p.m., the Medical Decision Making section indicated, .Patient is currently calm and cooperative .I discussed with [facility physician name] that if they feel he requires more care than they can provide this is something that they need to arrange for a transfer from [facility name]. There is no indication for patient to be admitted or transferred from the ER [emergency room ] today, given patient is confirmed on hospice and with extensive discussion earlier today with case management and administration decision was made for patient to ultimately be discharged back to [facility name] with continued hospice care .<br><br>Review of Resident 1's hospital record, Emergency Department Reports, dated 6/8/24, at 1:26 a.m., the Chief Complaint section indicated, Pt BIBA from [facility name]. Was originally sent back there and the staff refused to accept their patient back. He was abandoned and medics had to bring him back here.<br><br>Review of Resident 1's hospital record, Emergency Department Reports, dated 6/8/24, at 1:26 a.m., the Medical Decision Making section indicated, .Unfortunate case of patient returning to the ER as [facility name] refused to accept patient back after he was discharged a few hours ago from the ER back to his care facility . Has been calm and cooperative while in the ER .<br><br>During an interview on 6/26/24, at 8:28 a.m., licensed nurse (LN) 1 stated on 6/7/24, at 11 p.m., Resident 1 returned from the hospital in an ambulance with paramedics accompanying him. LN 1 stated Resident 1 was brought up to the door on a stretcher and was denied entrance to the facility. LN 1 further stated, .We refused to take him back .<br><br>During an interview on 7/16/24, at 1:48 p.m., with the hospital Case Manager (CS), CS stated the facility would not accept Resident 1 back. CS further stated she did not receive any notice that Resident 1 was discharged from the facility because he was dangerous.<br><br>During an interview on 7/19/24, at 2:15 p.m., with the Hospice Doctor (HD), HD stated, .The facility should have taken him back .That's the place he lives. He should be allowed back. They should have reached out to our team if the facility felt the resident was a danger. We have social workers that work with other facilities to find placement .The hospital can't keep him because of his hospice (a program that provides specialized care to people who are near the end of life and have stopped treatment to cure or control their disease) diagnosis. The facility doesn't want him back, a man without a place to stay .We tried to adjust meds, but couldn't move too fast and have to go slow with them . The HD indicated a conversation should have taken place to assess Resident 1's care needs.<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. During an interview on 7/16/24, at 1:35 p.m., with the Medical Director (MD), MD stated Resident 1 was on hospice and was not his patient. MD confirmed he did not document the reason for Resident 1's discharge from the facility or if he considered Resident 1 unsafe to remain at the facility. MD stated no one from the facility asked him to document the basis for Resident 1's discharge. MD further stated the discharge documentation should have been handled by hospice and completed by the hospice physician.<br><br>During a concurrent interview and record review on 7/16/24, at 2:08 p.m., with the Social Services Director (SSD), Resident 1's EHR was reviewed. SSD confirmed there was no physician documentation which justified Resident 1's discharge.<br><br>During an interview on 7/16/24, at 3:05 p.m., with the Administrator (ADM), ADM acknowledged there was no physician note found in Resident 1's chart that documented why Resident 1 was discharged from the facility or why he was considered unsafe to remain in the facility.<br><br>During an interview on 7/19/24, at 2:15 p.m., with the Hospice Doctor (HD), HD stated Resident 1 was his hospice patient. HD confirmed he did not document Resident 1's discharge and was not asked by the facility to justify the discharge. HD stated a conversation should have happened between the facility and his team to determine if it was not appropriate for Resident 1 to stay in the facility.<br><br>Review of the facility policy titled, Transfer or Discharge Notice, revised March 2021, indicated, .The reasons for the transfer or discharge are documented in the resident's medical record .<br><br>3. During a concurrent interview and record review on 7/16/24, at 2:08 p.m., with the SSD, Resident 1's EHR was reviewed. SSD confirmed no discharge notice was given to Resident 1 or his RP. SSD stated a discharge notice was given in advance for a facility-initiated discharge or it was given as soon it was known. SSD further stated she expected a discharge notice be given to a resident and the RP if a resident was considered unsafe to remain at a facility. SSD explained the purpose of the discharge notice was to let the resident and the RP know and prepare them for the discharge. SSD stated it was the responsibility of the social services department and the MDS (minimum data set- an assessment tool) nurse to provide the discharge notices. SSD further stated not providing a discharge notice could affect a resident's family's ability to coordinate care at home. SSD stated she did not know if a discharge notice should have been given to Resident 1 when facility staff refused to admit the resident back from the hospital on the evening of 6/7/24.<br><br>During an interview on 7/16/24, at 3:05 p.m., with the ADM, ADM acknowledged a written discharge notice was not provided to Resident 1 or his RP. ADM stated she verbally told the RP, but the RP was on a cruise. ADM further acknowledged a discharge notice could have been given to the next emergency contact for Resident 1. ADM stated she did not document her conversation with the resident's RP in Resident 1's EHR.<br><br>During an interview on 7/19/24, at 2:40 p.m., with the ADM, ADM confirmed a written notice was not provided to the LTC Ombudsman when Resident 1 was no longer at the facility and was discharged . ADM stated she called Ombudsman to notify them Resident 1 was being sent to the hospital and would not be returning because Resident 1 was considered unsafe to remain at the facility due to his aggressive/ combative behaviors. ADM further stated she did not document her conversation with the Ombudsman in Resident 1's chart but she should have. ADM stated she considered it as a discharge when a resident went home, went to a lower level of care or when a resident was no longer in the facility's care.<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Transfer or Discharge Notice, revised March 2021, indicated, .Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge . The safety of individuals in the facility would be endangered .The health of individuals in the facility would be endangered .The resident and representative are notified in writing of the following information .The specific reason of the discharge .A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative . |