STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555871	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Subacute and Care	151 Claydelle Ave El Cajon, CA 92020

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 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** 46247 Based on interview and record review, the facility failed to readmit one of three sampled residents (Resident 1), who was transferred to a General Acute Care Hospital (GACH) for medical care, when the facility did not document a reason for refusal to readmit Resident 1 after GACH 2 had deemed Resident 1 medically and psychologically safe for discharge back to the facility according to facility policy. This deficient practice placed the resident at risk for confusion and psychosocial harm related to the inability to return to the facility and an unnecessary, extended stay at the GACH 2. Findings: Resident 1 was admitted to the facility on [DATE] with a diagnosis of suicidal ideations (thoughts about or a plan to commit suicide) and chronic respiratory failure (a condition that makes it difficult to breathe on one's own) requiring a tracheostomy (a surgical procedure that creates an opening in the neck to provide an alternative airway for breathing) and ventilator (a machine that helps patients breathe) per the facility's admission record. A review of Resident 1's Post-Event IDT Review, dated 9/2/24, indicated Resident 1 was transferred and admitted to GACH 1 on 8/31/24 for attempted self-harm after he was discovered in his room with a charger cord wrapped around his neck and he verbalized a plan to kill himself. The Post-Event IDT Review indicated Resident 1's room was prepared for return to the facility by removal of potential self-harm items and that staff were in-serviced regarding care and monitoring on resident safety. A review of Resident 1's Post-Event IDT Review, dated 9/12/24, indicated Resident 1 was readmitted to the facility on [DATE] following an acute care admission at GACH 1 for a suicide attempt on 8/31/24. The IDT Review recommended Resident 1 be assessed for suicidal intent every shift. A review of Resident 1's History and Physical Examination (H&P), dated 9/13/24, indicated, . transferred back to the hospital . after reportedly wrapping a cord around his neck at his post-acute facility . deemed psychiatrically stable for discharge back to post-acute facility . The H&P indicated Resident 1 had a documented history of chronic passive thoughts of self-harm on a daily basis. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 11:04 AM, an interview was conducted with certified nursing assistant (CNA) 1 at the facility. CNA 1 stated the facility accepted residents with psychiatric conditions. CNA 1 stated the facility provides in-services that review interventions for psychiatric residents that have a history of harming themselves. CNA 1 stated staff were trained to periodically take inventory of resident drawers for items that were used to self-harm and frequent visual checks. CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 had history of trying to hurt himself and stated he had previously attempted to wrap a cord around his neck at the facility. CNA 1 stated the facility accepted him back from the hospital after this incident and safety interventions were put in place. CNA 1 stated Resident 1 was recently sent out for attempting to hurt himself by drinking hydrogen peroxide rinse (a diluted solution of hydrogen peroxide used to clean the mouth of bacteria). On 11/21/24 at 11:36 AM, an interview was conducted with facility licensed nurse (FLN) 1 at the facility. FLN 1 stated she was the nurse for Resident 1 the day he swallowed the hydrogen peroxide oral rinse. FLN 1 stated Resident 1 was transferred out to GACH 2 per the NP's order. FLN 1 stated Resident 1 had suicidal ideations in the past. FLN 1 stated Resident 1 had previously gone to the hospital for putting a cord around his neck. FLN 1 stated safety interventions were put in place after the hospital stay which included placing cords out of reach, removing sharp items and liquids from the room, and making sure no medications were left on the counter. FLN 1 stated the facility conducted in-services on suicidal ideations which included not leaving any type of liquids at the bedside. FLN 1 stated Resident 1 had not stated or verbalized an intention to hurt anyone else and was not physically aggressive towards others. FLN 1 stated Resident 1 had signed a seven-day bed hold. FLN 1 stated care plan for suicidal ideation was created for Resident 1 following the ingestion of hydrogen peroxide oral rinse. A review of Resident 1's nursing progress note, dated 11/11/24 at 6:02 P.M., indicated Resident 1 was ordered to be transferred to GACH 2 by the nurse practitioner (NP) after he reported he drank something he found in his drawer and verbalized that he wanted to die. The note indicated registered nurse (RN) 1 found an empty 2-ounce bottle of hydrogen peroxide oral rinse near the resident. A review of Resident 1's physician's orders (PO) indicated an order to transfer to GACH 2 was placed on 11/11/24. A review of the facility document, completed for Resident 1, titled, eINTERACT Transfer Form V4.1 (ETF), dated 11/11/24 at 7:20 P.M, indicated, B. Transfer Details . Reason(s) for: Other: suicidal attempt/ideation . 2. Primary Goals of Care at Time of Transfer; 1. Rehabilitation and/or Medical Therapy with intent of returning home . 3. Conditions of Return . Nursing Home Would be able to Accept Resident Back Under the Following Conditions . 1. ED determines diagnoses, and treatment can be done in NH (nursing home); 2. VS (vital signs) stabilized and follow up plan can be done in NH . (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 2:18 P.M., an interview with the facility case manager/social services director (CM/SSD) was conducted at the facility. The CM/SSD stated Resident 1 was transferred out to GACH 2 after an attempted suicide by trying to drink a solution. CM/SSD stated Resident 1 had a seven-day bed hold. CM/SSD stated GACHs notified the facility when a resident was ready to discharge from the hospital and return to the facility. CM/SSD stated the director of nursing (DON), and the care team reviewed the hospital discharge paperwork and would readmit the resident for transfer if there was a bed available. The CM/SSD stated she had spoken with GACH 2 who stated Resident 1 had been cleared for discharge. The CM/SSD stated she had spoken with Resident 1 over the phone, and he reported not feeling stable. The CM/SSD stated she told the hospital the facility did not feel they could accept the resident back. The CM/SSD stated the facility had not gone to the hospital to assess Resident 1. The CM/SSD stated she had not reported to anyone at GACH 2 regarding Resident 1's reports of feeling unstable. A review of Resident 1's social services progress note, dated 11/18/24, at 3:08 P.M., authored by the CM/SSD, indicated, .Spoke with CM (case manager) from [name of hospital] to explain why [name of facility] is not the appropriate setting for this resident . The facility is not a psych facility . The facility has concerns the resident would attempt suicide again . it is of the utmost importance that the resident gets the care that he needs and not get put back into a LTC (long term care) without regular psych visits and meetings. The facility would rather the resident be safe in a psych related facility . On 11/25/24 at 11:46 A.M., a follow-up telephone interview and record review of Resident 1's clinical record was conducted with CM/SSD. The CM/SSD stated she had spoken to Resident 1 on the phone multiple times and was concerned about readmitting him. CM/SSD stated she did not document any of the phone calls she had with Resident 1. CM/SSD stated the interdisciplinary care team (IDT) discussed reasons for not wanting to readmit Resident 1 to the facility at their clinical meeting. CM/SSD acknowledged the clinical record did not contain documentation that indicated the reasons why the facility determined they were no longer able to care for Resident 1. The CM/SSD stated the full discussion of why the facility did not want to accept Resident 1 back from the hospital was not reflected in the clinical documentation. A review facility social services progress notes, dated 9/16/24 through 11/10/24 were conducted. The social service progress notes did not indicate Resident 1 was exhibiting suicidal ideation, mood, and behavioral issues the facility was unable to accommodate during this time period. On 11/25/24 at 1:52 P.M., an interview with the facility nurse practitioner (NP) was conducted. NP stated she was readmitted to the hospital following a recent suicide attempt. The NP stated Resident 1 was in the hospital two months ago following a previous suicide attempt. The NP stated she had read the facility progress notes indicating the resident was not returning to the facility because the facility was unable to meet Resident 1's needs. The NP stated she was not involved in the decision to not accept the resident back from the facility. A review of the facility document, dated 11/11/24, titled, Physician Discharge Summary, indicated Resident 1 was discharged to the hospital on 11/11/24. The section of the document, titled, DISCHARGE DIAGNOSIS, was left blank. The section of the document, titled, A FINAL SUMMARY OF RESIDENT'S STATUS AT TIME OF DISCHARGE, was left blank. The document included a physician signature, dated 11/11/24. The document did not indicate the reason for the hospital transfer or that the facility was unable to provide ongoing care for Resident 1's psychological need. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Post-Event IDT Review, dated 11/11/24, indicated Resident 1 was transferred and admitted to GACH 2 for verbalizing wanting to die and consuming a bottle of hydrogen peroxide oral rinse found in his drawer. The Post-Event IDT Review recommendations included emergency room evaluation for self-harm intent, a psychiatric evaluation, follow-up with the acute care facility regarding resident discharge planning, staff training, and a re-evaluation of Resident 1's preferred activities by the activity department. An inability to care for the resident's psychosocial needs upon discharge from the hospital was not documented. The NP and medical doctor were not listed as IDT members involved in the IDT review. A review of GACH 2 case manager note, dated 11/13/24, indicated, .Called and spoke with [Marketer name] @ [facility name] and is able to return if he's doing better . A review of GACH 2 case manager note, dated 11/18/24, indicated, .Called [Marketer name] back . agreed to accept patient back tomorrow at 10am . transportation set up for tomorrow @ 10am . A review of GACH 2 document titled, Discharge Summary, dated 11/19/24, indicated, .Patient is now cleared by psychiatrist for discharge back to skilled nursing care facility . A review of GACH 2 nurse note, dated 11/19/24, indicated, .Patient is discharge back to [facility name] today and scheduled for pick up at 10 am. A review of GACH 2 case manager note, dated 11/19/24, indicated, .Unable to transport patient d/t - facility not accepting per [CM/SSD name] . On 11/21/2024 at 4:00 P.M., a telephone interview was conducted with the director of case management at GACH 2 (GACH 2 DCM). GACH 2 DCM stated Resident 1 was still at the GACH 2 and had been medically and psychologically cleared for discharge back to the facility. GACH 2 DCM stated, on 11/19/24, the facility notified GACH 2 they were unable accept Resident 1 back to the facility. On 12/13/24 at 4:06 P.M., an interview with the director of nursing (DON) was conducted. The DON stated the facility accepted Resident 1 back to the facility after the first suicide attempt involving the cord around his neck because they felt they could provide a safe environment for Resident 1 and manage his psychological needs. The DON acknowledged the facility did not document why the facility was unable to care for Resident 1's needs following the second suicide attempt. The DON acknowledged the facility did not follow their policy on transfer and discharge requirements. A review of the facility census, dated 11/20/24, indicated 8 of 42 total beds were empty and unoccupied. The census indicated there were no new pending admissions. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, titled, Criteria for Transfer and Discharge, revised 12/2023, indicated, .Policy: It is the policy of this facility that each resident will remain in the Facility, and not be transferred or discharged unless the discharge or transfer is appropriate as per the existing criteria. When the Facility transfers or discharges a resident, the Facility shall ensure that the transfer or discharge is documented in the resident's medical record . Procedure: The Facility shall permit each resident to remain in the Facility, and not transfer or discharge the resident from the Facility unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility . 5. If the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility, the resident's physician shall document the following in the resident's medical record: a. The specific resident need(s) that cannot be met; b. Facility attempts to meet the resident needs; and c. The service available at the receiving Facility to meet the need(s) . 10. If the Facility determines that a resident, who was transferred with an expectation of returning to the Facility cannot return to the Facility, this constitutes a discharge and this policy shall apply. Therefore, a refusal to readmit the resident to the Facility is considered a discharge, and the requirements of 42 CFR Section 483.15 in terms of documentation, notice before transfer, and orientation for transfer/discharge apply .

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46247 Based on interview and record review, the facility did not have a written transfer agreement in place with a General Acute Care Hospital (GACH) when the facility ordered a resident (1) to transfer to GACH 2 for medical and psychological treatment. This failure could potentially place residents at risk for inadequate continuity of care and treatment. Findings: Resident 1 was admitted to the facility on [DATE] with a diagnosis of suicidal ideations (thoughts about or a plan to commit suicide) and chronic respiratory failure (a condition that makes it difficult to breath on one ' s own) requiring a tracheostomy (a surgical procedure that creates an opening in the neck to provide an alternative airway for breathing) and ventilator (a machine that helps patients breathe) per the facility's admission record. Resident 1's was transferred and admitted to GACH 2 on 11/11/24 for verbalizing a desire to die and consuming a bottle of hydrogen peroxide oral rinse (a diluted solution of hydrogen peroxide used to clean the mouth of bacteria), per the facility's Post-Event IDT record. A review Resident 1's physician's orders (PO), dated 11/11/24, indicated Resident 1 was ordered to transfer to GACH 2 for further assessment. On 11/21/24 at 11:36 AM, an interview was conducted with facility licensed nurse (FLN) 1 at the facility. FLN 1 stated she was the nurse for Resident 1 the day he swallowed the hydrogen peroxide oral rinse. FLN 1 stated Resident 1 was transferred out to GACH 2 per the nurse practitioner's (NP) order. On 11/25/24 at 12:15 PM a telephone interview with the director of nursing (DON)was conducted . A request for a copy of the facility's hospital transfer agreement with GACH 2 was made. On 11/25/24 at 3:40 PM, a follow-up telephone interview with the director of nursing (DON) was conducted. The DON stated the facility did not have a written transfer agreement with GACH 2 on file. The DON stated he checked with the facility's contract department and the facility did not have a written transfer agreement for any GACH the facility transferred patients to on file. The facility was not able to provide a record of a written transfer agreement with GACH 2 or any other GACH upon request. The facility did not provide a policy on transfer agreements upon request.