POC Recveived: 12/19/24
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055855	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN PARK POST ACUTE	3400 ALTA ARDEN EXPRESSWAY SACRAMENTO, CA 95825

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00933675. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 660 SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 12/16/2024

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.

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(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the

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clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop and implement an effective discharge planning process when Resident 1 was discharged home without proper arrangements for home health services to manage the wound and therapy services.

This failure resulted in Resident 1 ' s not having wound care for over 8 days which had the risk potential for the wound to get infected and deteriorate in functional status due to therapy services not provided.

Findings:

A review of the admission record indicated the facility admitted Resident 1 in the fall of 2024 with multiple diagnoses which included aftercare for surgical wound that got separated and caused a life-threatening infection due to ruptured appendix (lower end of intestine). Resident 1 ' s medical history indicated that the resident had a recent colostomy (a surgical opening in which a piece of colon was removed and a new opening was created and a small pouch was attached to collect and remove waste material).

A review of Resident 1 ' s clinical records

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contained a document titled, "Notice Of Proposed Transfer/Discharge," dated 11/26/24 which indicated the resident was to be discharged home on 11/27/24. The document indicated, "Per Resident Insurance his health has improved sufficiently that the resident no longer requires skilled nursing that facility is providing. May safely DC [discharge home] to lower level of care."

A review of a physician order dated 11/26/24, at 2: 15 p.m., indicated, "May discharge home ...PT [physical therapy]/OT [occupational therapy] for strengthening. RN [registered nurse] for wound care."

A review of Resident 1 ' s clinical records contained a progress note dated 11/26/24, at 6:39 p.m., indicating the resident was to be discharged to his sister ' s home and be followed by home health agency (HHA) for wound care, medication management, and therapy for strengthening. The note indicated, "Spoke to sister she is aware and agreed plan of discharge 11/27/24."

A review of Resident 1 ' s clinical records did not contain physician order or other documentation indicating the date the resident was to start HHA services.

A review of ' POST-DISCHARGE PLAN OF CARE (POC), ' DATED 11/26/24 contained Resident 1 ' s wound care instructions, listed some of his medications, and listed contact information of his physician and pharmacy. The POC indicated, "Please, contact us if you have further questions." The POC did not contain any

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information indicating the arrangements had been made with home health agency and did not specify what home health services were ordered to achieve resident ' s discharge needs and goals and, when the services were to begin.

In a telephone interview on 12/5/24, at 8:10 a.m., Resident 1 stated that before his discharge on 11/27/24, he was told by a case manager (CM) that the home health services had been arranged and home health nurses will do wound dressings the same way he had his wound care done every day at the facility. Resident 1 stated he was assured the HHA will be seeing him within 24 to 48 hours after his discharge from the facility, but he had not been contacted by HHA for over a week. Resident 1 stated that he had called the HHA a few times and every time they told him that they had not received his documents. Resident 1 stated he made multiple attempts to contact the facility and to talk to CM, but every time he called, his calls were transferred to voice message box that was full and he was not able to leave a message for CM. Resident 1 stated he was attempting to change his wound dressings by himself, but it was uncomfortable, and he had run out of wound supplies. Resident 1 stated, "I ' m scared that my wound will get infected again because the dressing is all soggy and soiled. I almost died in September when my incision got infected and opened up." Resident 1 added he did not know what to do in this situation and might need to go the emergency room to have his wound taken care of.

During an interview and a concurrent record review on 12/5/24, at 8:50 am., the Case Manager Nurse (CMN) stated her responsibility

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in the process of a resident discharge was to ensure a safe discharge to home or another place. The CMN stated she verbally discussed Resident 1 ' s needs for wound care and therapy with home health agency ' s staff and the agency accepted the resident. The CMN stated she faxed Resident 1 ' s referral documents which included order for HH services on 11/26/24, the day before the resident was discharged from the facility. The CM stated she did not follow up with the HHA to assure that they received Resident 1 ' s referral documents and was not aware that the resident had not been seen by HHA for 8 days after his discharge. The CMN acknowledged that the resident ' s clinical records did not contain documented evidence when the resident ' s referral was faxed to the agency. The CM stated she did not have a fax confirmation with the date and the time the referral was faxed to the agency, but stated she would look for it.

During a telephone call to HHA on 12/5/24, at 9:35 a.m., the agency ' s staff (AS) stated the agency had not received Resident 1 ' s referral documents until 12/2/24, 6 days after the resident was discharged from the facility. The AS stated the agency still had not scheduled to see Resident 1 because they were waiting for insurance authorization.

During an interview on 12/5/24, at 9:40 a.m., the facility ' s nurse practitioner (NP) stated that Resident 1 was discharged from the facility on 11/27/24 with home health services. The NP validated that Resident 1 ' s discharge order did not specify the date the resident was required to start HH services, and added, "The expectation is that the patient will be seen within 48 hours after

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discharge." The NP stated Resident 1 ' s discharge summary was not done because the facility did not inform NP that the resident had left the facility. The NP added that nobody had informed her Resident 1 had not received services from HHA .

During an interview and a concurrent record review on 12/5/24, at 10:52 a.m., the Assistant of Director of Nursing (DON) stated Resident 1 had "a relatively new colostomy" and large surgical wound that had not healed yet. The ADON reviewed Resident 1 ' s nursing progress notes and stated that upon discharge, the resident was given wound care supplies for 4 days with the expectation that home health nurse will follow up within 48 hours and will perform wound care and colostomy care with their supplies. The ADON stated she was not aware the resident had not been seen by home health nurses for 8 days since he left the facility and acknowledged that the resident probably run out of wound supplies provided upon discharge.

During an interview with the Director of Nursing (DON) in the presence of Nurse Consultant (NC) on 12/5/24, at 3 p.m., the DON did not provide the answer when asked if Resident 1 ' s discharge planning was effective and if the discharge was safe.
A review of the facility ' s ' Discharge Summary and Plan, ' policy, dated 2001, indicated that when a resident ' s discharge was anticipated, a discharge summary and post-discharge plan will be developed to assist the resident with discharge. The policy indicated, "Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. The

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post-discharge plan is developed ...with the assistance of the resident and his or her family and includes ...arrangements that have been made for follow up care and services ..,a description of the resident ' s stated discharge goals ...the degree of caregiver/support person availability, capacity and capability to perform required care ...what factors may make the resident vulnerable to preventable readmission ...how those factors will be addressed ...Residents ...discharged to a home health agency ...are assisted in selecting ...a care provider that is relevant and applicable to the resident ' s goals of care and treatment preferences."

During a joint interview with Administrator (ADM) and CMN on 12/5/24, at 3:15 p.m., the ADM stated, " ...Big miscommunication ...They [HHA] did not reach out and we assumed ...there were no questions and the resident receiving their services." The ADM stated the facility were unable to locate fax confirmation that the referral was sent on 11/26/24. The ADM verified fax machine activity log for 11/26/24 and 11/27/24 and was unable to locate the recipient ' s (HHA) fax number and the transmission report, confirming the date and the time of transmission of Resident 1 ' s referral to home health agency.