DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555333	A. BUILDING _____ B. WING _____	C 03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN MEADOWS CARE CENTER	1550 THIRD STREET LINCOLN, CA 95648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 #CA00828697 and complaint #CA00829926. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 41054 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. The Department substantiated a violation of the regulations for complaint #CA00828697 and complaint #CA00829926 and the findings are written at F-624.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 2) was safely discharged when, the resident was mistaken for another resident (Resident 1) and transported and left at the wrong address.	F 624		

Rcvd 4/7/23 Aprvd 4/11/23 BIC 4/26/23

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

Kenneth Blankenfeld | Administrator | 4/7/23

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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F 624	Continued From page 1	F 624		

This failure had the potential to jeopardize Resident 2's health and safety.

Findings:

Acording to the Resident Face Sheet, Resident 1 was admitted in early 2023 with diagnoses including fracture of the lower end of the left tibia (shin bone) and fibula (calf bone).

According to the Resident Face Sheet, Resident 2 was admitted in early 2023 with diagnoses including pneumonia, sepsis (a life-threatening complication of an infection) and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors).

A MDS (Minimum Data Set, an assessment tool), dated 2/16/23, indicated Resident 2 had moderate cognitive impairment.

A review of Resident 2's clinical record included the following documents:

A Discharge Summary, dated 2/24/23, indicated Resident 2 was discharged to his home that day with a referral to hospice (a type of health care for the terminally ill which prioritizes comfort and quality of life by reducing pain and suffering).

A Progress Note, dated 2/24/23 and written by Licensed Nurse 1 (LN 1), indicated Resident 2 had been discharged home with his wife and left the facility via a transport van and one attendant.

A GACH (General Acute Care Hospital) Hospice Client Coordination Note, dated 2/25/23, indicated that on 2/24/23 the hospice nurse had

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F 624	Continued From page 2 waited with Resident 2's RP (Responsible Party) for the resident to arrive home from the facility. The note indicated the nurse phoned the facility and was told Resident 2 had left the facility at 5:05 p.m. but did not arrive home until 7:45 p.m. In an interview, on 3/9/23 at 2:36 p.m., Resident 2's RP stated she was present when Resident 2 was discharged from the facility and had been picked up by a transportation service. The RP stated the Driver 1 (DR1) did not ask Resident 2 his name and no staff were present when DR 1 took the resident. The RP stated she waited over 3 hours for Resident 2 to arrive home. In an interview, on 3/13/23 at 11:55 a.m., Certified Nursing Assistant 1 (CNA 1) stated she had cared for Resident 2 the day he was discharged. CNA 1 stated she had taken Resident 1 to the lobby to wait for his transportation with his RP. CNA 1 stated she did not stay with Resident 2 because his RP was there and if she had not been there, CNA 1 stated she would have remained with him until he was inside the van. In an interview, on 3/13/23 at 12:44 p.m., the Receptionist (RT) stated on 2/24/23 there were 2 residents (Resident 1 and Resident 2) that had been discharged and waiting in the lobby for transportation. The RT stated she spoke to DR 1 and he confirmed he was there to transport Resident 2. The RT stated DR 1 went back to the nursing station and spoke with nursing staff, then returned to Resident 2 and loaded him into the van and left. The RT stated about 15 minutes later another driver arrived at the facility and stated he was there to pick up Resident 2. The	F 624		

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F 624	Continued From page 3 RT stated the second driver took Resident 1 to his discharge address, picked up Resident 2 who had been left there in error, and took him to his home. In an interview, on 3/13/23 at 5:10 p.m., DR 1 stated he normally checked the resident's name before transporting him by asking the resident himself, but acknowledged he did not do that with Resident 2. DR 1 stated he later learned he had taken the wrong resident and had dropped Resident 2 off to another facility in error. In an interview, on 3/15/23 at 3:13 p.m., the Director of Nursing (DON) confirmed Resident 2 was taken to the wrong address when he was discharged on 2/24/23. The DON agreed that the facility had responsibility, along with DR 1, to ensure the right resident was taken to the right address. A review of the facility's policy titled, "Transportation, Social Services," last revised 12/08, stipulated, "Social Services will help the resident as needed to obtain transportation."	F 624		

CA00828697 & CA00829926

The filing of this plan of correction does not constitute an admission that the deficiencies allegedly did, in fact, exist. This plan of correction is filed as evidence of the facility's efforts to comply with the requirements of participation and to continue to provide quality resident care.

F 624

1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

- Resident was taken to the correct destination after the detour and was discharged at the time and is no longer a resident.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- Any resident discharging has the ability to be affected.

3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

- An inservice will be provided to LN's to also share patients name to the Driving Company's Driver upon pickup to ensure they know they are picking up the correct patient and going to the correct location.

4. How the facility plans to monitor its performance to make sure that the solutions are sustained, The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:

- Social Services will audit DC's for 1 month to determine if resident were taken directly to the correct location and report to QA meeting to determine if additional action in needed.

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency:

- Inservice initiated on 4/2/23. Follow up will be during next QA Committee meeting scheduled for 4/19/23.