STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056007	A. BUILDING _____ B. WING _____	C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFIC CARE NURSING CENTER	3355 PACIFIC PLACE LONG BEACH, CA 90806

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint and a Facility Reported Incident. Complaint Number: CA00811888 Facility Reported Incident (FRI) Number: CA00811878 Representing the Department: Health Facilities Evaluator Nurse: 45269, HFEN, RN The inspection was limited to the specific complaint and FRI investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the complaint number CA00811888 (Refer to Ftag 624). No deficiency was issued for the FRI number CA00811878.	F 000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280. F624 How corrective action(s) will be accomplished for those residents found to have been affected be the deficient practice: Resident 1 has been readmitted to our facility. Discharge planning will be based on the discharge goal of the resident and the facility will coordinate a safe and appropriate placement based on the resident's needs.	
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	F 624	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: The Social Services Director (SSD) will identify any residents that are planning to discharge from the facility. The SSD will verify that there is an order for discharge, contact any referral services, and make follow up calls post discharge to identify if the resident had an concerns.	

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

Administrator 12/27/2022

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 by: Based on observation, interview, and record review, the facility failed to ensure a safe and orderly discharge for one of two resident (Resident 1) who had a Stage 4 sacral pressure injury (a deep wound in the bottom of the spine reaching the muscles, ligaments, or bones) and an indwelling catheter (a flexible tube that a clinician passes through the urethra and into the bladder to drain urine) by failing to: a. Ensure Resident 1 was not discharged to a lower level of care facility which was not trained to provide services for a resident with an indwelling catheter and pressure injury. b. Provide and arrange the necessary services, wound assessment ,wound care treatment, and indwelling catheter care as ordered by the physician. These deficient practices had the potential to place Resident 1 at risk for not receiving adequate care and services and resulted in worsening pressure injury. Findings: During a record review of Resident 1 ' s face sheet, the face sheet indicated Resident 1 was admitted to the facility on 6/11/2020, with diagnoses that included diabetes (high blood sugar), muscle wasting, anemia (low blood count), obesity, Escherichia coli urosepsis (systemic infection of the urinary tract caused by a bacteria called Escherichia coli) and motor vehicle accident injury. During a record review of Resident 1 ' s History	F 624	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Prior to the discharge of a resident, the facility interdisciplinary team will conduct a care conference meeting with the resident or resident representative to discuss plan of care including discharge planning goal. The nursing department will obtain a physician's order for discharge. SSD or designee will contact all referrals services (i.e. home health, medical equipment, etc.) as well as make a phone call to the discharged resident or representative within one week post discharge. The Director of Nursing (DON) initiated inservice for nurses on 11/30/22 on discharge and transfers. The DON provided a one-on-one education to the SSD on 12/22/22 regarding discharge, transfers, and discharge process. The Quality Assurance Performance Improvement (QAPI) committee will review the policy and procedure for discharge process in the next meeting.	

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F 624	Continued From page 2 and Physical (H&P) dated 6/12/22, the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P also indicated the presence of a pressure injury on the sacral area. During a record review of Resident 1 ' s Minimum Data Set (MDS- standardized screening tool) dated 9/18/22, MDS indicated Resident 1 had intact cognition (ability to think, decide, remember, and learn new things) and required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and was totally dependent on staff when transferring from the bed to the wheelchair. The MDS also indicated Resident 1 had a Stage 4 pressure injury. During a record review of Resident 1 ' s Wound Progress Notes dated 10/26/22, the progress note indicated Resident 1 had a stage 4 pressure injury measuring 4.4 centimeters (cm) x 3.7 cm. x 1 cm. with 10 percent slough (dead tissues that needs to be removed from the wound for healing to take place) and 90 percent granulating tissue (new tissues are forming) and the size of the wound was slightly increased with a stable wound bed. It also indicated Resident 1 was discharging to an Assisted Living (for people who need help with daily care,but not as much help as a nursing home provides [AL]) facility that day. During a record review of Resident 1 ' s Physician ' s Order (PO), the PO indicated a written discharge order dated 10/26/22 to discharge Resident 1 to a facility located in Redlands, CA. The PO indicated to make arrangements for wound care services and home health (wide range of health care services that can be given in your home for an illness or injury) for physical	F 624	How the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will review on a monthly basis how many discharges have occurred and will review at least two social service documentation regarding discharge. The Administrator will ensure that the SSD or designee had coordinated discharge according to the plan of correction and facility discharge process policy and procedure. Completion Date: January 3, 2023	

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F 624	Continued From page 3 therapy. During an interview on 11/29/22, at 10:30 am with Social Worker (SW) 1, SW 1 stated Resident 1 was discharged to a boarding care (a senior living facility licensed to care for 6 to 20 residents who need some assistance, but do not require ongoing skilled nursing care). During an interview on 11/29/22, at 11:30 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 1 had a Stage 4 pressure injury on the sacral area and an indwelling catheter for wound management. LVN 2 stated he performed a skin assessment of the pressure injury during discharge and the wound was getting smaller and granulating (new tissues are forming on the surfaces of the wound). During an interview on 11/29/22, at 2:45 p.m. with RN Supervisor (RN Sup) 1, RN Sup. 1 stated she discharged Resident 1 on 10/26/22. RN Sup.1 stated , when discharging a resident all arrangements are made for medications, any home health services for physical therapy, wound care services or medical equipment needed and explained to the resident for safety reasons. During a phone interview on 11/29/22, at 3:01 p.m. with the Wound Care Company, the number that was documented for the discharge order was not for the Wound Care Company but for the Wound Care Group that used to see Resident 1 for wound care services when she was in the facility. During an interview on 11/29/22, at 3:15 p.m. with SW 1, SW 1 stated, she spoke with the Outside Referral Specialist (ORS) about the referral for	F 624		

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F 624	Continued From page 4 wound care services, but could not remember the name of the person whom she talked to about the wound care services. She stated the facility sometimes uses an outside referral agency to help place residents to another facility. During a phone interview on 12/1/22, at 8:02 a.m. with the Outside Referral Specialist (ORS), the ORS stated Resident 1 was placed in a room and board (provide residents with a room, a bed and prepared meals for a set price) facility not a boarding care. ORS stated room and board are for residents that can take care of themselves where meals are prepared, served, and clothes are washed by the facility. She stated the facility did not mention anything about the presence of an Indwelling catheter, pressure injury and inability of resident to ambulate during referral. ORS stated the facility was in a hurry to move the resident to another facility or place, and it was a rookie mistake on her part for not checking the condition of the resident. She stated she received a call from the facility on 10/25/22 to place Resident 1 and on 10/26/22 Resident 1 was discharged to room and board. ORS stated another referral was made for wound care, which was arranged for Resident 1, because the company that was supposed to see Resident 1 was not able to provide the care due to distance. During an interview on 12/12/22, at 10:15 a.m. with the owner of room and board, the owner stated they only take residents who are independent, able to walk and can take their medications on their own. She stated ORS told her, Resident 1 was independent, had no catheter and no presence of pressure injury. She stated, "When I got the resident around noon, I saw the resident had an indwelling catheter,	F 624		

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F 624	Continued From page 5 wounds and the resident needed help with a lot of things. The owner stated she could not provide services and care for Resident 1, who had an indwelling urinary catheter because she was not trained to care for this type of resident. She stated the room and board did not even have a Hoyer Lift (mechanical device used to assist in transferring a patient in the nursing home from bed to chair or other similar resting places) to help Resident 1 move or transfer. During an interview on 12/13/22, at 3:11 p.m. with SW 1, SW 1 stated it was important to discharge Resident 1 safely to prevent hospitalizations due to inadequate care. During a phone interview on 12/14/22, at 10:17 a.m. with SW 1, SW 1 stated that it was not safe for Resident 1 to be discharged to a room and board facility because the resident did not have the support for her medical needs and care. During a record review of Resident 1 ' s hospital ' s record, Resident 1 was admitted to the hospital on 11/9/22 for worsening sacral wound. The hospital record indicated a Magnetic Resonance Imaging (MRI -procedure that uses radio waves, a powerful magnet and a computer to make a series of detailed pictures of areas inside the body) was done on 11/10/22 which indicated the presence of osteomyelitis on the S5 vertebra and coccyx (infection of the bone in the lower spine). A review of the GACH Discharge Summary (DS) dated 12/5/22, indicated there was a consultation conducted by the infectious disease physician, who ordered to infuse intravenous antibiotics to Resident 1 for six weeks. The DC Summary further indicated a Wound Vac (vacuum assisted	F 624		

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F 624	Continued From page 6 closure -method of decreasing air pressure around the wound to assist healing) was applied on Resident 1 ' s sacral wound to facilitate healing. During a record review of facility ' s policy and procedure(P&P) titled" Discharge Process" revised 10/17, the P/P indicated discharge planning process must focus on discharge planning goals and should prepare a resident to be an active partner in their post discharge care and transition process to reduce factors leading to preventable readmission. The P&P also indicated the facility will provide and document sufficient preparation and orientation to residents for transfer or discharge to ensure a safe and orderly transfer or discharge from the facility.	F 624		

Pacific Care NURSING CENTER

In-Service Training Log

* A= Day P= Evening N =NOC Shift

COURSE TITLE:	When discharging and transfering of patients, ensure to document patient teaching, and discharge instructions, use language that is easily understand by patients, and the follow up care (ie: cath care, and woud care.
DATE AND TIME:	30-Nov-22
ATTENDEES:	
PRESENTED BY:	Marianne Roldan DON

Name	Job Title	Dept	Shift	Signature
Miriam Ibarra	RN	SAH	7A-7P	
RT Ligot	LVN		7AP	
Anna Mae Cenas	LVN	SAH	7A-7P	
Maryful P. Abad	RN	SA	7A-7P	
Eileen Nguyen	LVN	SNF	7A-3P	
Le Estela	RN	SA's	7A-7P	
Marta McIntosch	LVN	NSG	7A-5P	
CAM BANTIGUI	LVN	NSG	7-3	
Raoul Lengson	LVN	SNF	3-11	
Marianne Arnedo	LVN	SNF	3-11	
Mary-May Francisco	LVN	SNF	3-11	

Pacific Care
NURSING CENTER

In-Service Training Log

* A= Day P= Evening N =NOC Shift

COURSE TITLE:	Discharge Planning
DATE AND TIME:	12/22/22.
ATTENDEES:	
PRESENTED BY:	Marianne Roldan DON

Name	Job Title	Dept	Shift	Signature
JHERUZA PLATA.	SSD	SS.	9M	

Manual: Nursing	Page: 1 R/V: 10/2017
Subject: **Discharge Planning Process**	

Policy: It is the policy of the facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals.

Procedure:

Preparing residents to be active participants and effectively transition them to post discharge care can reduce factors leading to preventable readmissions. The discharge planning process should:

- Identify the discharge needs of each resident and result in the development of a discharge plan.
- Include re-evaluation to identify changes with residents that require modification of the discharge plan. The discharge plan should be updated as necessary, to reflect any changes.
- Involve the IDT in this ongoing process of developing the discharge plan.
- Consider caregiver/support person availability and the resident's or caregiver's support person(s) capacity and capability to perform the required care, as part of the identification of the resident's discharge needs.
- The resident and their representative should be involved in the development of the discharge plan and informed of the final plan.
- Address the resident's goals of care and treatment preferences.
- Document that the resident has been asked about their interest in receiving information regarding returning to the community.
- If a resident expresses an interest in returning to the community, the facility should document any referrals to local contact agencies or other appropriate entities for this purpose.
- The facility should update the 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.

- If discharge to the community is determined to not be feasible, the facility will document who made the determination and why this determination was made.
- For residents transferred to another skilled nursing facility or discharged to a HHA, IFR or LTCH, the facility will assist residents and their representatives in selecting a post-acute care provider by using data that includes, SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent available. The facility should ensure that all the data is relevant and applicable to the resident's goals of care and treatment preferences.
- The facility will document an evaluation of the resident's discharge needs and discharge plan based on the resident's needs. This will be documented timely and the evaluation will be discussed with the resident or their representative. All relevant resident information should be incorporated into the resident's discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

Manual: Nursing	Page: 1 R/V: 09/2017
Subject: **Discharging the Resident**	

Purpose: The purpose of this procedure is to provide guidelines for the discharge process.

Preparation for Discharge

1. The resident should be consulted regarding the discharge.
2. Discharges can be frightening for the resident. Approach the discharge in a positive manner
3. Reassure the resident that all his or her personal effects, will be taken to his or her place of residence.
4. If discharging the resident to another long-term care facility tell the resident:
   a. Where the new facility is located.
   b. How large the facility is, what services it offers, what it looks like, etc. (if known).
   c. Any information you can about the facility. (Note: If you don't know, ask the supervisor about this information.)
   d. Who will be providing the resident's care (i.e., nurses, assistants, therapists, etc.).
   e. That his or her family and visitors will be informed of the discharge and where the resident will be living.
   f. Why the discharge is necessary (i.e., closer to home, relatives, etc.). (Note: If this information is not known, ask the supervisor this information.)
5. If the resident is being discharged home, ensure that the resident and/or responsible party receive teaching and discharge instructions.
6. If the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and that a telephone report is made to the receiving facility.
7. Assess and document the resident's condition at discharge, including skin assessment, if medical condition allows.
8. All ambulatory residents being discharged must be transported to the pickup area by wheelchair.
9. Assemble the equipment and supplies necessary to discharge the resident

Equipment and Supplies

The following equipment and supplies may be necessary when performing this procedure.

1. Stretcher or wheelchair;
2. Cart;
3. Soap and water;
4. Other equipment, as needed; and
5. Personal protective equipment (e.g. • gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached.
2. Wash and dry your hands thoroughly.

Discharging the resident to home or another Long-term care facility:

a. If visitors are present, tell them you are preparing the resident for discharge and to please wait outside until the bath has been completed unless the resident chooses to allow visitors to remain in the room.

b. Give the resident a bath. Follow established procedures. Dress the resident.

c. Be careful in packing the resident's personal effects, Encourage the resident to assist you in arranging the order of packing. (Note: Visitors may assist you in packing and transporting the resident's personal effects to the pick-up area.) Review the personal effects inventory with the resident or responsible party and have them sign that they have received all personal effects.

d. Collect the resident's personal effects. Put them on the cart for transporting to the pick-up area. Place cart where it will be out of the way until the resident is transported.

e. When the resident's transportation has arrived, assist the resident into the wheelchair. If the resident is in bed, close the cubicle

curtain while the resident is getting out of the bed. Open the cubicle curtain when the resident is dressed or in the wheelchair.

f. Transport the resident to the pick-up area. (Note: Allow the resident stops along the way to say goodbye to other residents and staff.)
g. Assist the resident into the automobile. Make the resident as comfortable as possible.
h. Assist the family in loading the resident's personal effects,
i. Say goodbye to the resident and family.
J. Return the wheelchair and wipe it with a disinfectant. Store in designated area.
k. Wash and dry your hands thoroughly.

4. **Discharging the resident to the hospital:**

a. Follow steps 1-2 above.
b. Pull the cubicle curtain around the bed.
c. If the resident's medical condition permits, bathe the resident. If not, put a clean gown or pajamas on the resident.
d. Make the resident as comfortable as possible.
e. Return the cubicle curtain to the open position.
f. Wash and dry your hands thoroughly.
g. Tell visitors that they may return to the room.
h. As soon as the resident's transportation arrives, ask visitors to step outside unless the resident chooses to allow visitors to remain in the room.
i. Close the room door. Assist the resident onto the stretcher or into the wheelchair. Cover with sheet or blanket as necessary.
J· Open the room door. Escort the resident to the pick-up area.
k. Assist in the loading procedures as necessary.
i. If a wheelchair was used in transporting the resident to the pick-up area, return it and wipe the wheelchair with a disinfectant. Store in designated area.
rn. Wash and dry your hands thoroughly.

5. **Discharging the resident to the mortuary:**

a. Follow steps 1-2 above.
b. Ask family members or visitors to please wait outside until the procedure is completed.
c. Pull the cubicle curtain around the bed. Close the door to the room.
d. Perform post-mortem procedures.
e. Wash and dry your hands thoroughly.
f. Open the cubicle curtain if it is a private room.
g. Tell the family or visitors that they may enter the room. Keep the room door closed. (Note: If family members or visitors are not present, stay with the deceased resident until the resident has been discharged to the mortuary if possible.)
h. As soon as the mortuary personnel arrive, ask visitors to step outside.

Steps in Procedure:

i. Close the door to the room. Assist with placing the resident onto the stretcher if requested. Cover the resident with a sheet or blanket.
j. Open the door to the room. Escort the resident to the pick-up area.
k. Assist in the loading procedures as necessary.
l. Return to your assigned section.
m. Wash and dry your hands thoroughly

6. **Return to the resident's room.**

7. **Knock before entering the resident's room, if applicable.**

8. **Strip and clean the discharged resident's bed.**

9. **Make the unoccupied bed.**

I 0. **Discard soiled linen in the soiled linen hamper.**

11. **Remove all unnecessary supplies and equipment. Store in designated area or return to supply area for cleaning and disinfection.**

12. **Discard all disposable items into designated containers.**

13. **Wash and dry your hands thoroughly.**

Documentation

The following information should be recorded in the resident's medical record:

I. The date and time the discharge was made.
2. The name and title of the individual(s) who assisted in the discharge.
3. All assessment data obtained during the procedure, if applicable.
4. How the resident tolerated the procedure, if applicable.
5. If the resident refused the discharge, the reason(s) why and the intervention taken.
6. The signature and title of the person recording the data.

Manual: Nursing	Page: 1 R/V: 10/2017
Subject: **Discharge Summary**	

Policy: It is the policy of the facility that when the facility anticipates discharge, a resident should have a discharge summary.

Procedure:

The discharge summary should include, but not be limited to the following:

- A recapitulation of the resident's stay in the facility that included, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.
- A final summary of the resident's status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the resident or the resident's representative. This should include items from the resident's most recent comprehensive assessment that is necessary to accurately describe the current clinical status of the resident.
- Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
- A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident's representative, which will assist the resident to adjust to his or her new living environment.
- The post-discharge plan of care should indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
- In addition to the above, the facility should convey the following information to the receiving provider when the resident is discharged or transferred:
    - Contact information of the practitioner responsible for the care of the resident;
    - Resident representative information, if applicable, including contact information;

- Advance directive information;
- All special instructions or precautions for ongoing care, as appropriate;
- Comprehensive care plan goals;
- All other information necessary, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.

- For residents discharged to home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident's representative. These instructions should be discussed with the resident and resident representative and conveyed in a language and manner they will understand.