STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LODI NURSING & REHABILITATION	1334 S. HAM LANE LODI, CA 95242

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review,the facility failed to notify the resident/resident's representative of the discharge, and the reason, in writing for one of four sampled residents (Resident 1). The facility also failed to document the phone numbers and address on the NOTICE OF TRANSFER AND DISCHARGE for advocacy groups the resident/resident's representative could contact if they chose to appeal the transfer of Resident 1 from the skilled nursing facility (SNF) to a lower level of care. This failure violated Resident 1's right to be informed regarding transfers and discharges, and had the potential to cause an unsafe discharge from the SNF. Findings: According to the admission record, Resident 1 was admitted to the facility with [DIAGNOSES REDACTED]. Resident 1's Minimum Data Set (MDS, an assessment tool), dated 4/3/20, revealed a Brief Interview of Mental Status (a tool to measure cognitive capacity) score of 3 out of 15 which indicated severe cognitive loss. During an interview with the social service director (SSD), on 4/29/20, at 10:45 a.m., the SSD confirmed she completes the NOTICE OF TRANSFER OR DISCHARGE and the facility, the ombudsmen, and the resident/resident's representative should receive a copy. The SSD verified a written copy of the form was not mailed to Resident 1's representative, and a copy was only sent with Resident 1 on discharge from the SNF. When the SSD was asked if the representative of Resident 1 was going to be at his discharge location, the SSD was unsure. During a review of Resident 1's history and physical examination [REDACTED]. During a document review of Resident 1's NOTICE OF TRANSFER OR DISCHARGE, dated 4/17/20, the document read, .You have the right to appeal this decision to the appropriate state long-term care agency at the address shown below. In addition, you may wish to contact the Office of the State Long-Term Care Ombudsman or the state agencies responsible for the protection and advocacy of developmentally disabled (DD Agency) . Further review of Resident 1's NOTICE OF TRANSFER OR DISCHARGE revealed the name, phone number, address, and email address for the State Long Term Care Appeal Agency, and the DD (developmentally disabled) Agency was blank. During an interview with the SSD on 4/29/20, at 10:45 a.m., the SSD confirmed the form should be filled out completely to notify the recipient of appeal rights, and to confirm the discharge location.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record, and facility policy review, the facility failed to re-evaluate and modify the transfer/discharge for one of four sampled residents (Resident 1) when Resident 1 had a change in condition and was discharged to a board and care (B & C-a lower level of care that provide personal care services) home without completing a 72-hour monitoring after an unwitnessed fall. This failure placed Resident 1's health and well-being at risk due to a premature discharge. Findings: Review of Resident 1's admission record revealed, Resident 1 was admitted to the facility with [DIAGNOSES REDACTED]. Review of Resident 1's Minimum Data Set, (MDS, an assessment tool) dated 4/3/20, revealed a Brief Interview of Mental Status (a tool to measure cognitive capacity) score of 3 out of 15 which indicated severe cognitive impairment. His history and physical (H & P) examination dated 4/6/20, indicated, .can make needs known, but cannot make medical decisions . Further review of the H & P indicated, his discharge plan was to go to a lower level of care. Review of Resident 1's RESIDENT CARE CONFERENCE REVIEW, dated 4/10/20, indicated, .D/C (discharge) plan is to return to previous B&C after 14 day quarantine. With HH (Home Health) services. B&C (B&C 1) requires resident to be ambulating (walking) for return . His Discharge Planning Review, dated 4/10/20, revealed, he was to Return home to his B&C. On 4/21/20, the Department received a report that Resident 1 was scheduled to be discharged from the facility on 4/17/20, after a 14-day quarantine and rehabilitation. The report indicated, Resident 1 was to be discharged to B & C 2 for an additional 14-day quarantine prior to returning to his regular B & C 1. The report further indicated, upon arrival at B & C 2, Resident 1 was unresponsive. Review of Resident 1's care plan dated 4/3/20, indicated, .High risk for falls and injury related to poor safety awareness, (and) cognitive impairment . Further review of his care plan revealed, Resident 1 had unwitnessed falls on 4/10/20, and 4/17/20. Review of Resident 1's progress notes dated 4/10/20, at 6:15 a.m., indicated, .patient (Resident 1) found lying on floor on right side vocalizing pain .noted with abrasion to right upper [MEDICATION NAME] (cheek) area, discoloration to right shoulder and .right side of back .72 hour charting initiated . His Neurological Assessment, (neuro check-an examination to check any abnormalities in the nervous system which includes the brain, spinal cord, and the nerves) dated 4/10/20, showed facility nursing staff completed the neuro check on 4/10/20, 4/11/20, 4/12/20, and 4/13/20. Review of Resident 1's progress notes dated 4/17/20, at 7 a.m., indicated, .Patient (Resident 1) was found on floor at approx. (approximately) 0640 (6:40 a.m.) this morning. .was found lying on R (right) side and had superficial scratch .to right side of chin .Initiated Neuro-checks . will continue to monitor for changes . His neuro checks dated 4/17/20, did not show documented evidence a 72-hour monitoring was completed by the facility nursing staff. Resident 1 was discharged at 2:35 p.m. on 4/17/20. In an interview with the Licensed Nurse (LN) 1 on 4/22/20, at 2:16 p.m., she stated, when discharging a resident, the resident should be stable with no fever, vital signs (clinical measurements such as pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) within normal limits, no abnormal laboratory values, and mental status at baseline (starting point for basis of comparison). She further stated, the discharge plan for a resident would be discontinued if resident was found unstable. In an interview with the social service director (SSD) on 4/22/20, at 3:20 p.m., she stated, when a resident reached his/her goals to prior level of functioning or better, and when medically cleared by the physician, a resident could be safely discharged to home, or to B & C. She continued, when a resident had a change of condition, the discharge order would be discontinued. Review of Resident 1's eINTERACT Change in Condition Evaluation V5, dated 4/10/20, and 4/17/20, revealed, a fall was considered a change of condition. The discharge plan should have been delayed and the 72-hour monitoring after his unwitnessed fall on 4/17/20 should have been completed. In an interview with the director of nursing (DON) on 4/22/20, at 5:41 p.m., she stated, residents with unwitnessed falls should have a 72-hour monitoring which included neuro checks per facility protocol. She further stated, she felt Resident 1's discharge was a safe discharge. In a phone interview with the Licensed Nurse (LN) 2 on 4/23/20, at 1:07 p.m., he stated, an unwitnessed fall would require a 72-hour monitoring including neuro checks. He confirmed, Resident 1 had an unwitnessed fall on 4/17/20, which was the day of discharge. LN 2 continued, he felt Resident 1's discharge was a safe discharge because there was no indication of any abnormalities. In a phone interview on 4/27/20, at 12:09 p.m., with the facility physician (MD), who was responsible for Resident 1, he confirmed he received a call from the facility on 4/17/20, regarding Resident 1's fall that morning. He also stated, he agreed to the facility's plan of care to continue monitoring and perform neuro checks for 72 hours. MD continued, he was not aware Resident 1 would be discharged that same day. He further stated, Resident 1's discharge plan should have been discontinued. In a phone interview with SSD on 4/27/20, at 2:05 p.m., she confirmed she received a phone order for

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

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) discharge on 4/17/20, but did not remind the MD of the fall Resident 1 had that morning. Review of Resident 1's PHYSICIAN'S DISCHARGE SUMMARY, dated 4/22/20, indicated, .He (Resident 1) was discharged on [DATE] .based on a planned D/C (discharge) order .He had a fall on 4/17 .Plan was to monitor for 72 hrs (hours) per protocol . Review of the facility policy titled, FALLS MANAGEMENT PROGRAM revised August 2013, indicated in pertinent parts, POST FALLS. .1. Following a resident's fall, the Licensed Nurse will assess the resident for injuries and necessary treatment .2. Licensed Nurse will immediately check the following .complete neuro checks for all unwitnessed falls .including level of consciousness .blood pressure, hand grip, dizziness .6. Licensed Nurses will document ongoing assessments including neurochecks .7. Licensed Nurses will also document response to care and treatment each shift for seventy two (72) hours . Review of the facility policy titled, CHANGES IN CONDITION undated, indicated in pertinent parts, .Changes in condition requires a minimum of 72 hours charting .examples of change in condition .changes in lab (laboratory) values .abnormal labs .resulting in further treatment .