STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555566	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONA POST ACUTE CENTER	**2600 SOUTH MAIN STREET CORONA, CA 92882**

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for one of three sampled residents (Resident A), the responsible party was provided the written information of the facility's bed-hold and return policy, including the duration of the state bed-hold policy, prior to the resident's transfer to the general acute care hospital (GACH). This failure resulted in the responsible party not being aware of the resident's rights for bed hold and return upon transfer out or therapeutic leave from the facility. Findings: On May 19, 2020, at 9:55 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to resident rights. The resident was no longer in the facility during the investigation. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated February 28, 2020, indicated the resident did not have the capacity to understand and make decisions. A physician's orders [REDACTED]. to facility d/t (due to) not suitable for environment / physical aggression non-redirectable. The progress notes, dated May 5, 2020, at 4:26 p.m., indicated, Emergency services called related to resident's aggressive and escalating behavior - striking staff with fist, destroying nurses station throwing food across floor, urinating on floor. Placed on a 5150 (by) emergency services . MD (physician) was notified - gave order for 3-day 5150 hold and requested do not readmit due to resident's escalating behavior -not appropriate for current SNF setting On June 22, 2020, Resident A's record was reviewed with the Director of Nursing (DON) and confirmed there was no documented evidence a written information of the facility's bed hold and return policy was provided to the resident's responsible party upon the resident's transfer to the GACH. There was also no documentation that the facility's bed-hold policy was explained or offered to the responsible party upon the resident's discharge/therapeutic leave from the facility. The facility's policy titled Bed-Hold and Returns, dated March 2017, was reviewed and indicated, .Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy . Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail .the rights and limitation of the resident regarding bed-holds . the reserve bed payment policy as indicated by the state plan . the facility per diem rate required to hold a bed . or to hold a bed beyond the state bed-hold period . and the details of the transfer .
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** Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident A), who was transferred to the general acute care hospital (GACH), was readmitted back to the facility on the first available bed. This failure resulted in the violation of Resident A's right to be readmitted back to the facility and had the potential to result in the resident's emotional distress and placement difficulties. Findings: On May 19, 2020, at 9:55 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to resident rights. The resident was no longer in the facility during the investigation. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated February 28, 2020, indicated the resident did not have the capacity to understand and make decisions. A physician's orders [REDACTED]. to facility d/t (due to) not suitable for environment / physical aggression non-redirectable. The progress notes, dated May 5, 2020, at 4:26 p.m., indicated, Emergency services called related to resident's aggressive and escalating behavior - striking staff with fist, destroying nurses station throwing food across floor, urinating on floor. Placed on a 5150 (by) emergency services . MD (physician) was notified - gave order for 3-day 5150 hold and requested do not readmit due to resident's escalating behavior -not appropriate for current SNF setting. On May 8, 2020, the GACH attempted readmission of the resident back to the facility but the facility declined Resident A's readmission. The facility's patient census from May 6, 2020 to May 13, 2020 was reviewed. The facility's census indicated there were vacant male beds available on the following days: - May 6, 2020, 11 vacant male beds - May 7, 2020, 11 vacant male beds - May 8, 2020, 14 vacant male beds - May 9, 2020, 14 vacant male beds - May 10, 2020, 14 vacant male beds - May 12, 2020, 11 vacant male beds - May 13, 2020, 9 vacant male beds On May 11, 2020, the resident's responsible party (RP) asserted the resident's right to readmission to the facility and filed an appeal through the Office of Administrative Hearing and Appeals (OAHA). The hearing was conducted on May 27, 2020 with the following findings: .Title 22, California Code of Regulations (22 CCR)) provides that upon transferring a patient to a hospital, a nursing facility must inform the resident or their responsible party, in writing of their right to exercise a bed-hold of seven days. A facility that fails to issue this notice, in writing, must offer the resident readmission to the first available bed. The bed-hold notification requirement is also contained in Title 42 Code of Federal Regulations (42 CFR) 483.15(d)(1) and (d)(2), wherein the facility must provide written information to the resident or resident's representative before and upon transfer that specifies the following: (i) the duration of the bed-hold policy; and (ii) the reserve bed payment policy. According to the Centers for Medicare and Medicaid Services (CMS), in an emergent transfer, Facility must provide written bed-hold notification to residents within 24-hours of the transfer. In this case, Facility's testimony and written documentation established that it did not offer Representative the requisite written bed-hold notice, on Resident's behalf, because it did not expect Resident to return. According to its testimony, Facility based this assumption on instructions from MD and CREST (Community Response Evaluation and Support Team) staff, who previously directed Facility, on April 20, 2020, to conduct Resident's permanent discharge to the GACH in the event that his behavior became too aggressive for it to manage. Facility did not offer an exemption or provision to demonstrate that these directives supersede the State and Federal regulations related to the bed-hold requirement Facility declined to readmit Resident when requested on May 8, 2020, during the seven day bed-hold period . Facility considered Resident's transfer to the GACH to be a permanent discharge. However . SNFs are required to comply with the above cited federal regulations related to transfer/discharge and readmission of its residents. Thus, Facility's characterization of Resident's hospitalization as a permanent discharge is a direct violation of these regulations. The purpose of hospitalization is to resolve an acute care need. Related to this, the Center for Medicare and Medicaid Services (CMS), holds that hospitalized residents are to be considered residents of the SNF they were residing at prior to their hospitalization . Therefore . Facility failed to comply with these state and federal bed-hold notification and readmission requirements . According to 42 CFR 483.15(e)(1) a facility must establish policies that provide for the immediate readmission to the first available bed in a semi-private room for any Medi-Cal eligible resident, whose hospitalization or leave exceeds the

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) bed-hold period. Because Facility refused to readmit Resident upon the GACH's initial request on or about May 8, 2020, his hospitalization has extended beyond the seven day bed- hold period. Facility did not dispute that it refused to readmit Resident, which is tantamount to an involuntary transfer. Facility argued that it is unable to readmit Resident due to his aggressive and combative behaviors. However, Facility cannot summarily effectuate a permanent discharge without complying with the federal and state requirements regarding such an action (42 CFR 483.15(c)(1) and HSC 1599.1). As part of these requirements, it must notify residents, or their authorized representatives, in advance and conduct discharge planning to locate an appropriate placement and comply with relevant documentation and orientation requirements. I considered that Facility may have outstanding issues with Resident's behaviors, as extensively discussed during testimony, however those issues are not grounds to refuse his readmission at this time, and Facility cannot refuse his readmission based on his behavior prior to his hospitalization . According to testimony and documentation from GACH staff, Resident has had some medication adjustments to address his disturbed behavior. Facility also has the option, as pointed out in Resident's psychiatric evaluation conducted at the GACH, to establish a .conservatorship to facilitate the administration of medications to him. Further, Facility is able to implement or resume interventions, such as regular consultation with psychological and psychiatric specialists, when possible; 1:1 monitoring; refresh or reinforce dementia training to staff; and maximize the use of male staff, to the extent it is able . Also considered that the aforementioned psychiatric evaluation conducted at the GACH on May 23, 2020, contained a recommendation that Resident be transferred to a geriatric psychiatric facility, given Facility's refusal to readmit him. However, as discussed above, the Facility has no legal standing to refuse Resident's readmission. Further . the GACH attempted to effectuate Resident's transfer to this acute psychiatric facility, to no avail. Therefore . Facility failed to support that it complied with these readmission requirements. When a facility determines that a resident cannot return, it must comply with the provisions outlined under 42 CFR 483.15(c) pertaining to the discharge of residents, which include but are not limited to issuing a written notice; providing sufficient preparation for discharge; and completing a post-discharge plan of care. In cases enumerating from an inability to meet a resident's needs, the SNF must identify the services at the receiving facility that will meet the specific needs that Facility could not meet. In this case, Facility did not provide a transfer/discharge notice, nor did it comply with other provisions cited above, such as locate and identify a long-term or other appropriate placement for Resident and enumerate how this locus would meet his needs; include documentation from a physician that specifies that Resident's behavior poses a risk to the safety of others at Facility; and complete a written post-discharge plan. On June 22, 2020, Resident A's record was reviewed with the Director of Nursing (DON) and confirmed the facility did not offer the bed-hold and did not accept the resident for readmission within the seven-day period or on the first available bed. There was also no documentation that the facility's bed-hold policy was explained or offered to the responsible party upon the resident's discharge/therapeutic leave from the facility. The facility's policy titled Bed-Hold and Returns, dated March 2017, was reviewed and indicated, .Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy . Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail .the rights and limitation of the resident regarding bed-holds . the reserve bed payment policy as indicated by the state plan . the facility per diem rate required to hold a bed . or to hold a bed beyond the state bed-hold period . and the details of the transfer . The California Code of Regulations for Bed Hold, Section , indicated: .If a patient of a skilled nursing facility is transferred to a general acute care hospital as defined in Section 1250(a) of the Health and Safety Code, the skilled nursing facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative . Upon transfer of the patient of a skilled nursing facility to a general acute care hospital, the skilled nursing facility shall inform the patient, or the patient's representative, in writing of the right to exercise this bed hold provision .Every skilled nursing facility shall inform each current patient or patient's representative in writing of the right to exercise the bed hold provision . A licensee who fails to meet these requirements shall offer to the patient the next available bed appropriate for the patient's needs. This requirement shall be in addition to any other remedies provided by law .