STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056428	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CALIFORNIA NURSING & REHABILITATION CENTER	**2299 NORTH INDIAN CANYON DRIVE PALM SPRINGS, CA 92262**

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for one of three sampled residents (Resident A), a safe and orderly discharge was provided to the resident when: a. Facility failed to implement a coordinated and smooth discharge for the resident; b. Facility failed to provide a safe medical transport during Resident A's discharge from the facility; and c. Facility staff failed to provide necessary documentation and communicate accurate information to the general acute care hospital (GACH), when the resident was rerouted to the GACH after a failed admission to another skilled nursing facility. These failures resulted in the resident's re-admission to the acute care hospital without proper endorsement and communication of the resident's status, necessary for continuity of health care services. These failures also had the potential to result in relocation stress syndrome or transfer trauma (physiologic and/or psychosocial disturbances as a result of transfer from one environment to another) to occur for Resident A. Findings: On July 13, 2020, at 8:45 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to transfer and discharge rights concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Resident Admission Assessment (RAA), dated June 21, 2020, indicated, .alert . confused . forgetful . anxious . disoriented . poor safety judgment . impaired balance . The RAA also indicated the resident required extensive assistance with bathing, dressing, hygiene, toileting, transferring, ambulating, and bed mobility. The nurse's notes, dated June 21, 2020, at 5:30 p.m., indicated, Received (Resident A) from (name of Skilled Nursing Facility (SNF) 1) via wheelchair, assisted by 2 male transporter. Pt. (patient) has an alarm on his hair, pleasantly confused, answers questions appropriately . The case management (CM) notes, dated June 23, 2020, indicated, CM attempted to contact admission and medical records at (SNF 1) for more info (information) of family contact. They do not have any further info regarding patient's contacts. The resident's medical record face sheet indicated no family member, representative, or contact person on file. The minimum data Set (MDS- a comprehensive assessment tool), dated June 23, 2020, indicated, .Brief Interview for Mental Status (BIMS - screening test used for mental and cognitive status) score of 7 (a score of 0-7 means severely impaired). A physician's orders [REDACTED]. The nurse's notes, dated June 23, 2020, at 2:00 p.m., indicated, .Discharge appropriate (@) at this time, left facility .via w/c (wheelchair) by transport. The social services (SS) notes, dated June 23, 2020, indicated, Social services received a call from our Marketing Director reporting she has found placement for the resident a bit closer to home. This writer spoke with the resident about moving-resident reported he would like to move . 3:00 p.m. resident left the facility with his personal belongings, medications and information for the new facility-resident left the facility in good spirits, via private auto. The GACH emergency department notes, dated June 23, 2020, at 9:45 p.m., indicated . chief complaint; psychiatric symptoms . with history of depression, anxiety, and mood disorder, who was walked over here for psychiatric evaluation . poor historian . It is unclear what his baseline is . The GACH social services notes indicated the following: - June 25, 2020, at 1:45 p.m., SS received a consult (6/24/2020) regarding assistance to obtain med (medical)/psych (psychiatric) history and attempting to reach family. Per chart review, the Pt is a 64 y/o (year-old) .who presented to the ED (reportedly Pt was accompanied by someone .) for psych eval . Pt was a walk-in and states failed transfer to psych facility. Pt transferred due to violent episodes per .paramedics . SW (social worker) (from) (SNF 1 stated) . never received any NOK (next of kin)/family information . SW met with Pt at b/s (bed side) . Pt was a/oX2 (alert, oriented times two) (person/place hospital) and confused. Pt stated the year is 2006. Pt was poor historian and unable to provide any specific detail. Pt was receptive to s/w SS. Pt was calm with congruent affect. Pt was able to articulate basic thoughts, needs, and feelings. Pt tended to mumble and this SW had to ask Pt to repeat responses. Pt was unable to answer most questions appropriately and made good eye contact. Pt appeared stated age and presented with fair hygiene/grooming . Pt was unable to provide information regarding circumstance and how he presented to the hospital. Pt stated he had been at another hospital and then stated, Well this one is better so I'm here. Pt stated .he got picked up by a woman and she brought him . Pt stated he has a sister/brother who both live in Texas, but pt could recall no identifying information and denied having other family . - June 26, 2020, at 4:43 p.m., .(Name of SNF 3 Admission Coordinator) informed she was not directly involved In pt's failed transfer, however pt was transferred to their facility but refused to go in . It Is unclear why Pt was taken by EMS (emergency medical services) to (GACH 1) ED . .(Marketing Director) confirmed pt was at (SNF 1) and was transferred by EMS to (SNF 3), however d/t (due to) behaviors Pt was declined for admission. (Marketing Director) was unsure why Pt was transferred to (GACH), but stated that EMS was involved in the transfer. (Marketing Director) stated she would need to f/u (follow-up) with the EMS company to understand why the Pt was brought to (GACH) ED, (Marketing Director) had no other information regarding the transfer and referred this SW to f/u with (SNF 1). - July 1, 2020, at 11:00 a.m., .received a call from (Marketing Director), (she) noted that she is trying to piece things together and inquired if there are placement issues for pt. (Marketing Director) noted that pt required a 1:1 sitter at their snf and .(SNF 2) transferred pt to (SNF 3) which has a locked unit. (Marketing Director) inquired if a report was filed w/ (with) ombudsman and dept (department) of public health . On July 13, 2020, at 8:55 a.m., Resident A was observed up in a wheelchair in the hallway of SNF 2. Resident was observed to be perusing through the magazine on top of a bedside table. The resident was mumbling with noted confusion. On July 13, 2020, at 9:03 a.m., Certified Nursing Assistant (CNA) 1 was interviewed regarding Resident A. She stated the resident was very confused with mental fluctuations, doesn't make sense when he talks, and required total care with activities of daily living. She further stated the resident had episodes of wandering in the facility. On July 13, 2020, at 9:44 a.m., the Administrator-in-Training (AIT) was interviewed and stated Resident A was admitted from SNF 1 and was supposedly to stay for only two days in the facility. She stated after two days, SNF 1 refused readmission of the resident, who was then discharged to SNF 3 which was handled by the Marketing Director. On July 13, 2020, at 10:53 a.m., the Marketing Director was interviewed and stated she arranged Resident A's admission with SNF 3's Marketing Director. She stated SNF 3 confirmed Resident A's admission and provided a room number. She stated she transported the resident herself to SNF 3. When asked who instructed her to transport Resident A to SNF 3, she stated, I took it upon myself. She stated she transported the resident since she was going to meet with the case managers and SNF 3's Marketing Director in the area. She stated she passed by (name of fast food center) to get food for the resident. When asked if she checked the resident's diet order prior to ordering fast food, she stated, No. She also stated she was not aware that the resident previously required a medical transport during the resident's discharge from SNF 1 to SNF 2. She stated the resident had episodes of anxiety behaviors while inside her car whenever she made speed changes. (The distance between SNF 2 and SNF 3 is 76 miles). On July 13, 2020, at 4:25 p.m., the GACH's Social Worker (SW) was

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) interviewed and stated Resident A had dementia (memory loss) and it was unclear how the resident go into the hospital. She stated the resident was brought in by paramedics on June 23, 2020, but there was not enough information or endorsement from any skilled nursing facility. She stated the resident did not have family and was unrepresented. On July 14, 2020, at 2:27 p.m., SNF 3's Director of Nursing was interviewed and confirmed they accepted the resident but was not admitted to their SNF due to the resident's behavior when he arrived the facility. He stated the resident went into their building at around 3 p.m. and was noted to be so confused . not safe in an open unit. He stated SNF 2's Marketing Directing previously told them the resident didn't require to be in a secured unit (locked unit- residents' movements are restricted for their safety). He stated they contacted SNF 2's Marketing Director to have the resident taken back to their facility. He stated SNF 2's Marketing Director came and picked up the resident. On July 14, 2020, at 3:07 p.m., a follow-up interview was conducted with SNF 2's Marketing Director. She stated she was having dinner with SNF 3's Marketing Director on June 23, 2020, when she received a call from SNF 3 and was told to take the resident back to their facility. She stated she tried to call a doctor at the hospital to admit the resident. When asked if she was a licensed nurse or medical practitioner, she stated she was not. She stated she transported the resident from SNF 3 to the GACH. (The distance from SNF 3 to the GACH is 9 miles). She stated her car broke down in the street just across the hospital so she called paramedics and stayed in her car while the paramedics took the resident in the acute care hospital. The facility's policy and procedure titled, Transfer or Discharge, dated January 2016, indicated: To ensure that adequate preparation and assistance is provided to resident prior to transfer or discharge from the facility. .Social Services Staff will participate in assisting the resident with transfers and discharges, and preparing the Discharge Summary and post discharge plan of care/discharge instructions . Social Services Staff will conduct a Discharge Planning Assessment, develop a post discharge plan of care, and will help orient the resident to the impending discharge . Discharge planning will begin on the resident's admission to the Facility . From the publication of Gerontological Society of America, in its article titled, Health Effects of the Relocation of Patients with Dementia: A Scoping Review to Inform Medical and Policy Decision-Making, dated April 2018, it indicated: .Relocation has previously been broadly defined as a move from one environment to another . In the context of care for older adults, this can entail the following types of move: interinstitutional (between two institutions), intrainstitutional (within one institution), residential (from home to home), and residence to/from institution . For the purposes of the current review, relocation will be defined as a move of person with a dementia [DIAGNOSES REDACTED]. Relocation of an ill individual is a complex process, which can lead to trauma, referred to as relocation stress: adverse health effects, such as dependency, confusion, anxiety, depression, and withdrawal, caused by (involuntary) relocations . .Nine studies found that relocation could lead to negative effects on a physical, psychological, and/or social dimension in the patient's life . Three of the studies found a decline in physical well-being related to relocation . Relocation was also found to result in decreased psychological and social well-being in seven articles . . The first determining factor of the severity of the effects of relocation on an individual with dementia is the pre-transitional physical and mental well-being of the patient. Although all patients in a nursing home are at risk for the negative effects of a move, persons suffering from dementia can experience more suffering. Life events, such as relocations, have a bigger impact on them, leading to higher stress levels and possibly negative health outcomes . As they often have difficulties verbalizing their needs and understanding changing situations, they are in need of an undisrupted daily schedule .which a relocation to a new environment is likely to jeopardize . The second factor that has a negative impact on patients with dementia who are relocated is abrupt changes in their schedule and continuation of care. As people suffering from dementia are in need of structured daily activities, continuous caregivers, and a fixed schedule, a disruption of this due to a relocation can be harmful . From the Board on Aging and Long Term Care Ombudsman Program's publication titled, Awareness: Relocation Stress Syndrome, dated April 2011, it indicated: Relocation Stress Syndrome, also called Transfer Trauma, is a formal nursing [DIAGNOSES REDACTED].' It is otherwise defined as 'the combination of medical and psychological reactions to abrupt physical transfer that may increase the risk of grave illness or death.' While relocation stress syndrome is sometimes minimized or even discounted, elders, especially those with cognitive impairments, may experience greater than average difficulties in adjusting to changes in routine. Having to move from one's home to a nursing home or assisted living facility (or even from one room to another) can result in confusion, depression and agitation. This may lead to increased falls, self-care deficits and weight loss.