STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056346	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEVIEW POST ACUTE	521 LOREL WAY YUBA CITY, CA 95991

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 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to complete the Comprehensive Minimum Data Set (MDS, a standardized resident assessment) within 14-calendar days of admission for one of five sampled residents (Resident 2), when the admission assessment was not completed until the 29th day of Resident 2's admission. This failure had the potential to delay the development of a comprehensive care plan necessary to provide the appropriate individualized care, and services for each resident related to the care areas identified on the comprehensive MDS. Findings: The Resident Assessment Instrument (RAI) Manual gives clear guidance about how to complete the MDS. According to the RAI, Chapter 2, Assessment completion refers to the date that all information has been collected and recorded for the particular assessment type, and staff have signed and dated that the assessment is complete. The comprehensive MDS assessments include the admission assessments. The comprehensive admission assessment completion date (Item Z0500B) must be no later than the 14th calendar day of the resident's admission (admitted +13 calendar days). Resident 2's medical record was reviewed on 2/28/20. Resident 2's clinical record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's admission MDS assessment dated [DATE], indicated all information had been collected and recorded for the assessment and staff had signed and dated that the assessment was complete (Item Z0500B) on [DATE], the 29th calendar day of Resident 2's admission. During an interview, on 2/28/20 at 2:30 pm, the MDS Coordinator, the registered nurse that verified the assessment was complete on [DATE], confirmed the assessment was not completed within 14-calendar days of Resident 2's admission.
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, and record review, the facility failed to ensure residents and their family members were involved in the development of the discharge plan for one of five sampled residents (Resident 2), when Resident 2 was discharged on short notice. This failure had the potential to result in the resident, and family members to feel anxious and overwhelmed with the discharge process. Findings: Resident 2's medical record was reviewed on 2/28/20. A review of Resident 2's clinical record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 2 was not able to make his own healthcare decisions and had responsible person (RP), to make decisions for him. A review of Resident 2's admission Minimum Data Set (MDS, a standardized resident assessment) dated 12/12/19, indicated Resident 2 expected to discharge to the community, however, he had severe cognitive impairment (ability to think and reason) and required extensive assistance from staff for tolieting and personal hygiene. A review of Resident 2's Speech Therapy Evaluation and Plan of Treatment, dated 12/3/19, indicated Resident 2 had good rehabilitation potential related to cognitive impairments. A review of Resident 2's Physical Therapy Evaluation and Plan of Treatment, dated 11/29/19, indicated Resident 2 would like to discharge home, however, his RP did not know if that would happen. The evaluation indicated Resident 2 demonstrated good rehabilitation potential. Resident 2 was able to follow one-step instructions and make his needs known. A review of Resident 2's Progress Notes dated 2/25/20 at 9:42 am, indicated that the Director of Nursing had noted Resident 2 exhibited aggressive behavior when he pushed another resident to the floor, who had wandered into his room. Resident 2 was also heard to say that if he had a gun, and that he would shoot the other resident. Resident 2's RP was contacted and a care conference was to be scheduled by Social Services with a focus to discharge Resident 2. A review of Resident 2's Progress Notes dated 2/25/20 at 10:21 am, indicated Social Services Assistant (SSA) contacted the RP, and scheduled a meeting with the Facility Administrator (FA) on 2/26/20 at 9 am. During an interview on 2/28/20 at 12:08 pm, the Social Services Director (SSD) stated she was informed by the FA that Resident 2 was involved in an allegation of abuse, and Resident 2 was not appropriate for this Skilled Nursing Facility. The SSD stated she was instructed to call the RP and tell her to come and pick up Resident 2. The SSD stated that Resident 2 owned his home, and had a right to go to his home even though his RP stated that she did not want Resident 2 to come home. The SSD stated that the RP had told her that if Resident 2 came home, the RP would move out. During an interview on 2/28/20 at 12:52 pm, the RP stated she was contacted by the SSD and was told that Resident 2 assaulted another resident. The RP stated she was told that she needed to come pick up Resident 2. If she did not come pick up Resident 2, the FA would drop Resident 2 off at home. The RP stated that she went to the facility, and brought Resident 2 home. The RP stated she was not involved in any discharge planning. The RP stated that Resident 2 was deemed capable of making his own decisions now. During an interview on 2/28/20 at 1 pm, the Medical Director (MD) stated Resident 2 had improved, so he had declared Resident 2 capable, and discharged him because of behaviors the facility could not handle. A review of Resident 2's Progress Notes dated 2/26/20 at 9:48 am, indicated Resident 2 was discharged home. During an interview on 2/28/20 at 1:15 pm, the FA stated the process for determining whether a resident could be discharged to the community was a multidisciplinary process that involved therapy, the family and the physician. The FA stated discharge planning was reviewed at least weekly throughout the resident's stay and the care plan was updated. When asked about the circumstances surrounding Resident 2's discharge, the FA stated that Resident 2 was involved in an altercation on [DATE], and was not appropriate to remain in the facility. At the time Resident 2 was not his own decision maker, so the FA stated he asked SSD to call the RP, and the RP did not want Resident 2 to come home. The FA then asked the MD to evaluate Resident 2, and MD declared Resident 2 capable, and discharged him that day. The FA stated that he had to do his best to arrange home health for Resident 2 at the last minute. The FA confirmed he had less than 24-hours to prepare for Resident 2's discharge. During an interview on 2/28/20 at 2:30 pm, the MDS Coordinator (MDSC) confirmed Resident 2 had expressed a desire to return to the community during his admission assessment. The MDSC stated all residents should have a discharge care plan, whether their plan was to return to the community or remain in the facility for long-term care. The MDSC confirmed that Resident 2 did not have a care plan to be discharged to the community.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that one of five sampled residents (Residents 2), records contained a complete discharge summary when the discharge summary did not contain a recapultation of the resident's stay. This failure could result in important health related information not being available for continued providers' use and could result in negative clinical outcomes. Findings: Resident 2's record was reviewed on 2/28/20. A review of

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 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident 2's clinical record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 2 was not able to make his own healthcare decisions and had responsible person (RP), to make decisions for him. A review of Resident 2's Admission Minimum Data Set (MDS, a standardized resident assessment) dated 12/12/19, indicated Resident 2 expected to discharge to the community, however, he had severe cognitive impairment (ability to think and reason) and required extensive assistance from staff for tolieting and personal hygiene. A review of Resident 2's Speech Therapy Evaluation and Plan of Treatment, dated 12/3/19, indicated Resident 2 had good rehabilitation potential related to cognitive impairments. A review of Resident 2's Physical Therapy Evaluation and Plan of Treatment, dated 11/29/19, indicated Resident 2 would like to discharge home, however, the RP did not know if that would happen. The evaluation indicated Resident 2 demonstrated good rehabilitation potential. Resident 2 was able to follow one-step instructions and make his needs known. A review of Resident 2's Progress Notes dated 2/25/20 at 9:42 am, indicated the Director of Nursing noted Resident 2 had exhibited aggressive behavior when he pushed another resident to the floor, who had wandered into his room. Resident 2 was also heard to say that if he had a gun, and that he would shoot the other resident. Resident 2's RP was contacted and a care conference was to be scheduled by Social Services with a focus to discharge Resident 2. A review of Resident 2's Discharge Summary, undated, indicated Resident 2 was to be discharged to his private residence. Item 3. Recap of the resident's stay: was blank. During an interview on 2/28/20 at 1:15 pm, when asked about the circumstances surrounding Resident 2's discharge, the Facility Administrator (FA) stated Resident 2 was involved in an altercation on [DATE], and was not appropriate to remain in this facility. The FA stated that he had to do his best to arrange home health for Resident 2 at the last minute. The FA confirmed he had less than 24-hours to prepare for Resident 2's discharge. The facility's policy titled, Discharge Summary and Plan, dated 12/2016, was reviewed and indicated that the discharge summary will include a recapultation of the resident's stay at this facility. During an interview on 2/28/20 at 2:35 pm, the Director of Nursing confirmed item 3. Recap of the resident's stay: was blank.