STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAMERCY COURT	**2200 GRAMERCY DRIVE SACRAMENTO, CA 95825**

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 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 effectively plan for the discharge of one of three sampled residents (Resident 1) to meet the resident's health and safety needs when the facility discharged Resident 1 to a room and board; unable to provide the require level of care to keep him safe. This failure resulted in Resident 1 going to the emergency department less than 24 hours after discharge due to his aggressive behaviors. Findings: Review of the facility's medical record for Resident 1 indicated he was admitted to the facility from the hospital in March 2020 with diagnoses, which included right [MEDICAL CONDITION] and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A care plan, dated 3/4/20, indicated Resident 1's Discharge plan IS TBD (To Be Determined). The discharge plan goal indicated, Will develop and follow full plan. The discharge plan approaches indicated, (Resident 1) Wishes to return home. The care plan did not indicate documented evidence of an update since it was initiated on 3/4/20. A care plan, dated 3/5/20, indicated Resident 1 was an elopement risk/wanderer, and the care plan approaches included 1:1 sitter x 72 hrs (hours) after admit then re-eval (re-evaluation). A Minimum Data Set (an assessment tool), dated 3/10/20, indicated Resident 1 scored zero on a memory test, which signified Resident 1 had severe short term memory loss. A social services note, dated 3/18/20, indicated the Social Services Director (SSD) sent a referral for Resident 1 to a local skilled nursing facility. The skilled nursing facility was a locked facility for residents with dementia type illnesses. Resident 1's medical record did not indicate documented evidence of the response of the referral made to the locked facility. Review of daily notes titled Health Status Note, written by nurses between the dates of 3/5/20 to 3/30/20, indicated Resident 1 had a sitter at his bedside daily. Several notes indicated the resident frequently tried to get out of bed to walk. The sitter was frequently unable to redirect the resident back to bed, the nurses frequently had difficulty redirecting the resident back to bed, the resident frequently wandered around the facility, he would occasionally refuse his medications, and would not complying with an order to limit weight bearing to heal his broken hip. A social services note, dated 3/25/20, indicated the SSD sent a letter of discharge notice to Resident 1's responsible party (RP, designated representative to make medical decisions for a resident), which indicated the resident would be discharged from the facility on 3/28/20. The note indicated, ALSO DISCUSSED AN OPTION OF PT (patient) BEING discharged TO A SUPPORTIVE HOUSING R&B (Room and Board, rooms for rent in a house that is unlicensed to provide care or supervision for its tenants), and that the RP agreed with the option. A nurse's note, dated 3/31/20, at 1:02 p.m., indicated, (Resident 1) became combative with CNA (Certified Nurse Assistant) and was able to be re-directed by sitter. Also, resident attempted to go into another room, but was taken out via wheelchair by sitter. Resident refused meds (medications) at first attempt but took them at 2nd attempt made by this nurse. Currently resident with 1:1 sitter going around the facility in wheelchair. will continue to monitor. A document titled IDT: Planned Discharge Summary, dated 3/31/20, at 2:36 p.m., indicated a section titled Physical Evaluation and Recapitulation of Stay. For mental status and psychosocial status, the document indicated n/a (not applicable), and for cognitive status, the document indicated good. The document did not include documented evidence of Resident 1's elopement risk or his need for a 1:1 sitter for supervision. A note titled Discharge Summary, dated 4/1/20, at 3:26 p.m., indicated, (Resident 1) has order to d/c (discharge) home today via transport. Discharge papers explained and discussed to (Resident 1)'s RP who verbalized understanding .Medication explained and given. (Resident 1) left the facility with stable condition at 12 (p.m.) via wheelchair, escorted by CNA with all belongings and medications. Review of Resident 1's general acute care hospital (GACH) medical record revealed a note titled, Clinical Social Services Crisis Services Progress Note, dated 4/1/20, at 7:29 p.m., which indicated Resident 1 was brought in to the emergency department at 7 p.m. by the operator of the room and board. The note indicated, .(Name of room and board operator) stated that patient is in need of a locked facility as he cannot currently care for himself . A GACH note titled Clinical Case Management Assessments, dated 4/3/20, at 9:15 a.m., and written by the GACH discharge planner (DCP) indicated the owner of the room and board returned Resident 1 to the emergency department after picking him up four hours prior, and was unwilling to take him back to the room and board. The note indicated the DCP contacted the skilled nursing facility's Admissions Department requesting to have Resident 1 return after his failed admission to the room and board. The note indicated the skilled nursing facility refused to accept Resident 1 stating the resident was assaultive to their staff and would benefit from a locked facility. A facility care plan for Resident 1, dated 4/16/20 (16 days after Resident 1 left the facility), indicated (Resident 1) desire to RETURN HOME. The goal indicated (Resident 1) will D/C (discharge) TO (name of room and board) safely and as planned with all services and education completed. The approaches indicated .Arrange for my local agencies of (name of agency) for my needs of RN (registered nurse), PT (physical therapy) before and set up services on my return to community. During an interview with the owner of the room and board (ORB) on 7/29/20, at 3:08 p.m., the ORB stated her house had alarms on the doors but was not a locked facility. The ORB stated she was restricted from going into the facility to conduct her assessment of the resident because of the facility's policy restricting non-essential visitors during a pandemic. The ORB stated she was not informed of the resident's need for a locked facility, and that he required a 1:1 sitter during his stay at the skilled nursing facility. The ORB stated her room and board home had care givers on-site 24 hours per day and was experienced with dementia type illnesses. The ORB stated Resident 1 became aggressive toward staff and other residents soon after arriving to the room and board. The ORB stated she became concerned about Resident 1's aggressive behavior and took him to the emergency department. The ORB stated she decided to take Resident 1 back to her room and board home with his new prescription for an anti-psychotic medication, but returned him four hours later for his increasing physical aggression. The ORB stated she found it too difficult to care for Resident 1 because she was in her final trimester of pregnancy, and needed her sleep. The ORB stated the other tenants in the home expressed fear and concern about Resident 1's aggressive behavior. During an interview with Resident 1's RP on 7/31/20, at 3:45 p.m., the RP stated she informed the facility's SSD of a recommendation made by Resident 1's primary care physician to place Resident 1 in a locked facility for long-term care. The RP confirmed the SSD presented her with the option of discharging Resident 1 to a room and board, and stated she agreed so long as the room and board could provide 24 hour nursing care and was a locked facility. The RP stated the SSD told her Resident 1 needed to be discharged by the end of the month, and that the room and board had alarms on the doors and could handle people with dementia. During an interview with the SSD on 8/4/20, at 11:30 a.m., the SSD stated the room and board had 24 hour care givers, had alarms on all doors to the outside, specialized in dementia care, and was available to low-income people. The SSD stated she felt Resident 1 would do well in a small, family-run home. During a follow-up interview with the ORB on 8/5/20, at 1:30 p.m., the ORB stated the SSD described Resident 1 as a very nice guy, he lived alone with no one to care for him, his family lived away, he suffered from dementia, he needed assistance with his activities of daily living, and that he had a fall and broke his hip. The ORB stated the SSD never told her the resident had a sitter for his entire stay at the facility, was frequently trying to get out of bed, staff had difficulty re-directing him to bed, he was an elopement risk, and he was non-compliant with care instructions. The ORB stated she

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) would not have accepted him into her room and board had she known this information about Resident 1. The ORB stated, on the day she went to the skilled nursing facility, she was not permitted to go passed the lobby due to their visitor restriction policy. The ORB stated the SSD met her in the lobby and gave her a face sheet (a document that provided information on demographics insurance, care provider contacts, emergency and family contacts, and diagnoses). During a follow-up interview with Resident 1's RP on 8/5/20, at 2:15 p.m., the RP stated she did not recall participating in the development of a discharge plan with members of the resident's interdisciplinary team. The RP stated the SSD did not inform her that the ORB was pregnant and had young children living in her room and board. The RP stated she would not have agreed to send Resident 1 to the home had she known this information, and stated Resident 1 was not comfortable living in a home with children. The RP stated she received a call from the ORB two hours after Resident 1's arrival informing her that Resident 1 was in the backyard trying to get out. The RP stated the ORB called again 20 minutes later to inform the RP she was taking the resident to the emergency department because she could not re-direct him back into the home. The RP stated the ORB told her she would not have accepted him had she known he was like this. During a follow-up interview with the SSD on 8/10/20, at 1:45 p.m., the SSD stated she sent a referral for Resident 1 to a local skilled nursing facility because it was a locked facility for residents with dementia. The SSD stated the locked facility denied the referral. The SSD stated the interdisciplinary team met daily to review each residents' progress, and that RPs did not necessarily participate but were notified of any changes. The SSD stated the ORB was not permitted to go passed the facility lobby due to a policy restricting non-essential visitors during to a pandemic, and the SSD stated she considered the ORB a non-essential visitor. The SSD confirmed the ORB did not have access to Resident 1's electronic medical record but stated she gave the ORB Resident 1's hard medical chart (binder with paper documents belonging to a resident's medical record) to review. The SSD stated the ORB did not request additional documents, and the SSD provided the ORB a copy of resident 1's face sheet and a document indicating Resident 1's lacked of capacity to make decision. During an interview with the Director of Nursing (DON) on 8/10/20, at 2:05 p.m., the DON confirmed the facility was restricting visitors and non-essential healthcare workers at the time the ORB came to the facility to do her assessment. The DON stated a resident's elopement risk was not normally included in a resident's discharge summary (a recapitulation of a resident's stay at the facility and a final summary of the resident's status at the time of discharge) provided to the receiving facility. The DON confirmed the document titled IDT: Planned Discharge Summary did not accurately reflect Resident 1's mental status, psychosocial status, and cognitive status. During an interview with the Medical Records Director (MRD) on 8/12/20, at 10:15 a.m., the MRD stated the contents of a resident's medical hard chart included the hospital reports, a consent to treat form, an immunization history form, a POLST (a document outlining medical orders for end-of-life care), admission orders [REDACTED]. The MRD confirmed the medical hard chart did not include nursing progress notes, physician progress notes [REDACTED]. Review of a facility policy titled Discharge Summary and Plan, revised 12/16, indicated, Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan The post-discharge care plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family .the discharge plan will be reevaluated based on changes in the resident's condition prior to discharge .The resident/representative will be involved in the post-discharge planning process.