STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555870	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELLA VISTA HEALTH CENTER	7922 PALM STREET LEMON GROVE, CA 91945

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 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 allow one of three residents (Resident 1), reviewed for facility-initiated transfers, to return to the facility after medically cleared by the hospital. As a result, Resident 1 was not allowed to return to the facility where he had resided for the past seven months. Findings: Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 1/7/20, a clinical record review was conducted for Resident 1: Resident 1's responsible party (RP) was listed, as friend. No address was listed for the RP, only a phone number. Resident 1's History and Physical, dated 8/7/17, indicated Resident 1 did not have the capacity to understand and make decisions. Licensed Nurse (LN 5) documented on the facility's Progress Notes, dated 9/2/17 at 7:51 P.M., Resident 1 shattered his bedroom window, when he threw his dinner plate at the window. LN 5 documented [MEDICATION NAME] (a medication that produces a calming effect) was administered with minimal relief. Resident 1 continued with verbal outburst and was transported to the hospital for evaluation. LN 6 documented on 9/3/17 at 6:30 A.M., Resident 1 returned from the hospital with [DIAGNOSES REDACTED]. Resident 1 was started on Keflex (a medication to treat urine infection) and [MEDICATION NAME] powder (a powder to treat skin infections). Resident 1's Progress Notes, titled IDT (Interdisciplinary Team), dated 9/5/17 at 4:13 P.M., .IDT (Interdisciplinary Team) discuss Resident 1's declining behavior, episodes of combative, verbal/physical outburst manifested by hitting staff .Today .resident up in Gerichair (a reclining chair) at nurses station .slapped an Activity staff on her right jaw . The IDT notes listed no planned interventions, no new care plans, and no changes to existing care plans to address Resident 1's behaviors. Resident 1's Progress notes, dated 9/5/17 at 6:30 P.M., LN 7 documented Resident 1 had been transported to the hospital for behavioral issues. Resident 1's Discharge Minimum Data Set (MDS-an assessment tool), dated 9/5/17, indicated the discharge was unplanned and Discharge Reporting was coded, return anticipated. Resident 1's care plan, titled Discharge Plan, dated 8/8/17, indicated, .Stay here at SNF (Skilled Nursing Facility) is anticipated to be long term . An intervention listed .Update resident/rp on any changes in discharge status . Resident 1's care plan titled, Mood/Behavior r/t (related to) anxiety, dated 8/8/17, listed interventions of report changes in condition to MD (medical doctor), will use disposable utensils, social service one on one as needed. On 1/14/20, Resident 1's hospital medical records were reviewed: The Hospital Social Worker (HSW 1) documented on the Summary Report, dated 9/20/17, .Bella Vista not accepting patient for readmission .Currently on call list for placement . HSW 1 documented from 10/12/17 through 10/26/17, Resident 1 had a urinary infection and was not cleared for discharge. HSW 1 documented weekly notes from 10/27/17 through 7/13/18, the names of numerous facilities who declined to accept Resident 1 for admission, due to no long-term beds being available, resident's history of aggression, or Resident 1's refusal to engage with admission evaluators during admission interviews. Hospital nursing staff reported to HSW 1, Resident 1 was cooperative with care. On 8/8/18, HSW 1 left a voice message for the facility's Administrator (ADM) regarding re-admission. On 8/10/18, the ADM returned the call and advised they would look into it and call HSW 1 back. HSW 1 did not hear back from the facility's ADM and left voice messages for the facility ADM on 8/20/18, 8/23/18 and 8/29/18. HSW 1 documented on 10/25/18, the facility ADM was contacted again by the HSW 1, regarding readmission. The ADM expressed concerns for readmission due to Resident 1's previous behavior. The ADM agreed to receive faxed clinical updates on Resident 1 to review. The HSW faxed the clinical information and left voice messages for the ADM to discuss readmission on 10/26/18, 10/30/18, and 10/31/18. The HSW notes did not contain any documented evidence the ADM returned any calls to the HSW 1. According to Resident 1's Hospital Discharge Summary, dated 5/1/19, Resident 1 was discharged to a long-term facility after, delayed hospital stay, secondary to placement issues. On 1/7/20 at 1:50 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 1's nursing notes and IDT meetings should have included ongoing evaluations of the resident's behavior management. The DON stated she only saw two nursing notes regarding Resident 1's aggressive behavior on 9/2/17 and 9/5/17. Resident 1's last IDT was on 9/5/17, before the resident was transferred to the hospital for evaluation. The DON stated if a resident started to display new behaviors, then laboratory test, urine analyses, and chest x-rays should always be completed first, to rule out any underlying medical issues. The DON stated if the behaviors were not corrected, a psychiatric evaluation should have been completed and staff in-serviced for behavior management and monitoring with a strict behavior plan. The DON stated she did not see any evidence a psychiatric evaluation was conducted for Resident 1 or that staff were in-serviced with a behavioral plan after 9/2/17 or 9/5/17. The DON stated the resident's behaviors and on-going management should then have been discussed and re-evaluated during on-going IDT meetings and there was no evidence it had been. The DON stated the last approach would be involving the medical director in Quality Assurance meetings. The DON stated each step for addressing, evaluating, correcting, monitoring, and modifying behavioral approaches would need to be documented and discussed during multiple IDT meetings, along with the medical director's input. The DON stated if all of these steps were not completed and documented, then Resident 1 should have been allowed to return to the facility. The DON requested time to discuss Resident 1's care with the Administrator (ADM), to see if any additional IDT or documentation could be located. On 1/16/20 at 1:48 P.M., an interview was conducted with the ADM. The ADM stated Resident 1 was not allowed back to the facility because he was considered a danger to staff and other residents. The ADM requested time to look for additional documentation to support why Resident 1 was not permitted to return to the facility. On 1/24/20 at 2:27 P.M., a subsequent interview was conducted with the ADM. The ADM stated she could not locate any documented evidence the facility attempted to address Resident 1's behaviors. The ADM stated there was no documented evidence the facility's Medical Director was involved in the decision to deny re-admission. The ADM stated there was no documented evidence a staff member went to the hospital to re-evaluate Resident 1, in order to determine if the resident's behavior was appropriate or inappropriate for re-admission. On 2/6/20, the facility census was reviewed from 8/11/18 through 9/9/18, during the time the resident was denied re-admission: 8/11/18, five male beds were available with no bed holds (bed holds- when a bed is held for 7 days, awaiting the resident's return from the hospital). 8/12/18, three male beds were available with no bed holds. 8/13/18, two male beds were available with no bed holds. 8/14/18, one male bed was available with no bed holds. 8/15/18, one male bed was available with no bed holds. 8/16/18, two male beds were available with no bed holds. 8/23/18, four male beds were empty with three bed holds. 8/31/18, six male beds were empty with two bed holds. 9/1/18, five male beds were empty with three bed holds. 9/2/18 through 9/4/18, five male beds were empty with two bed holds. 9/6/18, five male beds were empty with two bed holds. 9/7/18, four male beds were empty with two bed holds. 9/8/18 through 9/9/18, five male beds were available with one bed hold. According to the facility's policy, titled Readmission to the Facility, dated March 2017, . 1. A Medicaid resident whose hospitalization or therapeutic leave exceeds the bed hold period allowed by the state will be readmitted to the facility upon the first availability of a bed .

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.