STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555307	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEARWATER HEALTHCARE CENTER	**1517 EAST KNICKERBOCKER DRIVE STOCKTON, CA 95210**

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record, and facility document review, the facility failed to send a copy of the Notice of Transfer/Discharge to the Long-Term Care (LTC) Ombudsman (an official advocate representing the interest of the residents residing in the facility) for one of three sampled residents, (Resident 1), who was transferred/discharged to the local emergency room (ER). This failure had the potential for Resident 1 to not be protected from being inappropriately transferred or discharged . Findings: Clinical record review revealed Resident 1 was transferred to the localER on [DATE]. There was no documented evidence in Resident 1's clinical record that the LTC Ombudsman was notified when Resident 1 was transferred to the ER. In an interview with licensed nurse (LN) 1 on 12/18/19, at 1:46 p.m., she explained, she notified the LTC Ombudsman for other incidents but not ER transfers. She added, she had not called nor provided a written notice to the LTC Ombudsman for residents transferred/discharged to the local ER. In an interview with LN 2 on 12/18/19, at 2:01 p.m., she stated she informed everyone when residents were transferred/discharged to the local ER. She added she had not informed nor notified in writing the LTC Ombudsman for ER transfers/discharges. She said, I have not done it before. In an interview with the social service director (SSD) on 12/18/19, at 2:31 p.m., she explained her social service assistant (SSA) was responsible for faxing to the Ombudsman all notices of transfer and/or discharge to home or other facility including transfer/discharge to the local ER. In a concurrent interview and record review with the SSA on 12/18/19, at 4:20 p.m., she stated she faxed notices of ER transfer/discharge to LTC ombudsman the day after the transfer and/or discharge. Upon further record review, the SSA confirmed there was no documented evidence in Resident 1's clinical record that the LTC Ombudsman was notified when Resident 1 was transferred/discharged to the local ER. She added, .I could not find the fax transmittal . She continued, the Notice of Transfer/Discharge should have been faxed to the LTC Ombudsman. In a phone interview with the LTC Ombudsman on 12/19/19, at 1:01 p.m., she confirmed she received today Resident 1's Notice of Transfer/Discharge to the local ER. Review of the facility document (a fax confirmation), dated 12/20/19, revealed on 12/19/19, Resident 1's Notice of Transfer/Discharge to the local ER was faxed to the LTC Ombudsman office. The facility faxed the Notice of Transfer/ Discharge to the LTC Ombudsman after the matter was brought to their attention. In a phone interview with the administrator (ADM) on 2/26/20, at 10:49 a.m., he stated the Notice of Transfer/Discharge for Resident 1 should had been faxed to the LTC Ombudsman. He confirmed the notice was faxed on 12/19/19. Review of the facility policy titled, Notice of Transfer/Discharge revised December 2016, indicated in pertinent part, .2. Under the following circumstances, the notice will be given as soon as it is practicable .f. An immediate transfer or discharge is required by the resident's urgent medical needs .3. The resident and/or representative (sponsor) will be notified in writing of the following information .f. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman .4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and facility policy review, the facility failed to ensure one of three sampled residents, (Resident 1), received treatment and care in a timely manner when Resident 1 was denied hospice (medical care to help someone with a terminal illness to have quality of life) services for 7 days. This failure resulted in a delay for Resident 1 to receive hospice care and treatment that could potentially result in a further decline in psychosocial well-being. Findings: Review of Resident 1's admission record revealed, Resident 1 was admitted to the facility with [DIAGNOSES REDACTED]. Further review of the admission record also revealed, Resident 1 was transferred to the emergency room and was readmitted back to the facility on [DATE]. Review of Resident 1's clinical records, the baseline care plan (a tool that is intended to promote continuity of care and communication among the facility staff) undated, the discharge plan indicated, .LTC (Long-Term Care)/Hospice .Family spoke to (hospice agency) . Further review of Resident 1's clinical records, the care plan initiated 12/12/19, revealed comfort care. In addition, one of the interventions for this plan of care initiated 12/15/19, indicated, .Referral to hospice if indicated/desired by family . On 12/17/19, at 2:56 p.m., the Department received information that Resident 1 was denied hospice care since his re-admission back to the facility. The information also revealed, Resident 1 was declining in health and while he was in the acute care hospital, the family had contacted a hospice agency who would follow him when he returned to the facility. During initial observation on 12/18/19, at 12:51 p.m., Resident 1 was in bed with a nasal cannula (device used to deliver oxygen; device consists of a lightweight tube which on one end splits into two prongs which are placed in the nostrils) attached to an oxygen concentrator (device that filters surrounding air, compressing it to the required density and then delivering purified medical grade oxygen), he had an indwelling urinary catheter (drains urine from the bladder into a drainage bag outside the body), and he had a bandage wrapped around his right foot. Resident 1 opened his eyes and made eye contact but he was unable to respond to verbal commands. During an interview with the social service director (SSD) on 12/18/19, at 2:31 p.m., she stated, she was responsible in referring hospice services to hospice providers the facility had contract with or to the hospice agency the resident and/or family selected. SSD also stated, residents who needed hospice services should have a secondary payment source to pay for the room and board while at the facility. The SSD further stated, it would be the responsibility of Resident 1 and/or Resident 1's family members to pay for the room and board if they elected hospice services without a secondary payment source. She continued, the room and board expenses would cost $340 per day. She added, she did not make the referral to hospice services for Resident 1 when he was readmitted because he did not have a secondary payment source. In a subsequent interview with the SSD, she stated, she referred Resident 1 today to the hospice agency the family selected since Resident 1's payment source was confirmed pending. Resident 1 did not receive hospice services in a timely manner as specified in the baseline care plan. The interdisciplinary team (IDT, group of healthcare providers from different fields who work together or toward the same goal to provide the best care or best outcome for a patient) was aware of the discharge plan to LTC/Hospice for Resident 1. The hospice care and treatment was delayed for 7 days. During an interview with the administrator (ADM) and director of nursing (DON) on 12/18/19, at 3:15 p.m., they both confirmed, Resident 1's family requested hospice services since Resident 1's re-admission to the facility and that hospice care was initiated while resident was still in the acute care hospital. Review of Resident 1's progress notes dated 12/17/19 revealed, the ADM spoke to Resident 1's family members on 12/16/17 regarding their request for hospice services. The progress notes indicated, .Administrator spoke with family about the process of going on Hospice based on resident's

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) insurance coverage and health situation .cost of room and board without additional coverage is not covered under Hospice and would be private pay .It was suggested that resident could be sent back to the acute care hospital . In a phone interview with the ADM on 2/26/20, at 10:49 a.m., when asked if hospice services would have been initiated whether a secondary payment source was pending or not, ADM responded, It would be. In an interview with the SSD on 2/27/20, at 12:37 p.m., she explained the baseline care plan for Resident 1 was initiated the day after he was readmitted back to the facility. She further stated the baseline care plan should be completed within the first 48 hours of re-admission. The IDT had identified the discharge plan to LTC/Hospice for Resident 1 within the first 48 hours of his re-admission. The facility failed to initiate hospice services for Resident 1. Review of the facility policy titled, Care Plans - Baseline revised December 2016, indicated in pertinent parts, .1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed .2. The Interdisciplinary Team will .implement a baseline care plan to meet the resident's immediate care needs .3. The baseline care plan will be used .4. The resident and their representative will be provided .any services and treatments to be administered by the facility and personnel acting on behalf of the facility . According to the services agreement between the hospice agency and the facility, dated 9/17/2007, indicated, .4.5 Nursing facility shall be available to provide Nursing Facility Room and Board Services .twenty-four (24) hours a day, seven (7) days a week . Review of the facility policy titled, Hospice Program revised July 2017, indicated in pertinent parts, .Hospice services are available to residents at the end of life .8. When a resident has been diagnosed as terminally ill, the .will contact the hospice agency .that a visit/interview with the resident/family be conducted .9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions .10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs .and ensure that the level of care provided is appropriately based on the individual resident's needs. These include .a. Twenty-four hour room and board care .