STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555356	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUARTZ HILL POST ACUTE	**2120 BENTON DRIVE REDDING, CA 96003**

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 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the discharge for one of three residents (Resident 1) was safe when: 1. Home Health was not arranged as ordered by Resident 1's physician. 2. No education regarding [MEDICAL CONDITION] (operation in which a part of the intestine is diverted to an opening in the abdominal wall requiring an ostomy bag to be worn over the opening to collect feces) care was given to the family. 3. Ostomy care supplies given to Resident 1 upon discharge were inadequate. As a result, Resident 1 did not have the care and supplies she needed at home, causing pain and anxiety and had the potential to result in a hospital readmission. Findings: A review of Resident 1's record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. 1. The facility's policy, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 12/2016, was reviewed. It indicated, 6. If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse, or Director of Nurses (DON) will meet with the resident to: a. determine why the resident is requesting, refusing, or discontinuing care or treatment; b. try to address the resident's concerns and discuss alternative options; and c. discuss the potential outcomes of consequences (positive and negative) of the resident's decision.9. The interdisciplinary team will assess the resident's needs and offer the resident alternative treatments, if available and pertinent, while continuing to provide other services outlines in the care plan. 11. Detailed information relating to the request, refusal, or discontinuation of care or treatment will be documented in the resident's medical record. 12. Documentation pertaining to a resident's request, discontinuance or refusal of treatment shall include at least the following: . g. The date and time the practitioner was notified as well as the practitioner's response;: .13. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. A review of Resident 1's physician orders [REDACTED]. It indicated, Resident will be discharging to Oregon with son on 3/13/20 with current medications (plus narcotics), nursing home health and PT (physical therapy) eval, and any DME (durable medical equipment) as followed: No DME at this time. A review of the Physician's Discharge Summary, indicated the discharge date to be 3/14/20. It also indicated resident was to discharge home with home health to follow. A review of the Interdisciplinary Team (IDT-group of healthcare disciplines that discuss resident's plan of care) Discharge Summary, signed by Resident 1 on 3/14/20, indicated the resident refused home health services. During an interview on 8/24/20 at 8:45 am, FM stated home health had not been arranged to follow up after Resident 1's discharge. FM stated Resident 1 was unable to care for her [MEDICAL CONDITION] and since he had received no education or instruction on ostomy care, they needed home health to teach them. During an interview on 8/27/20 at 11:25 am, the Social Services Director (SSD) stated it was her role to talk with the family about discharge, order medical equipment or supplies, and arrange for home health when ordered by the physician. She stated Resident 1 refused home health and she could care for her own ostomy and didn't want more physical therapy. She stated she did not tell the charge nurse or the physician about this. SSD confirmed she should have told the charge nurse about Resident 1's refusal for home health. During an interview on 8/27/20 at 3:20 pm, the DON agreed the refusal of home health should have been discussed with IDT so they could have discussed it with the resident. 2. The facility's policy titled, Discharge Summary and Plan, dated 12/2016, indicated, 1. When the facility anticipates a resident's discharge to a private residence, another nursing facility, a discharge summary and a post-discharge plan will be developed which will assist the residents to adjust to his or her new living environment. . 4. Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan. 5. The post-discharge plan will be developed by the Care Planning / IDT team with the assistance of the resident and his or her family and will include: a. Where the individual plans to live b. Arrangement that have been made for follow up care and services . 12. A member of the IDT will review the post-discharge plan with the resident and family at least 24 hours before the discharge is to take place. During an interview on 8/24/20 at 8:45 am, FM stated Resident 1 was unable to take care of her [MEDICAL CONDITION] and changed her ostomy bag properly, so it was leaking and making the area around the stoma irritated. FM stated he had not received any education or instructions regarding care of the [MEDICAL CONDITION] before Resident 1 was discharged . A review of the nursing notes in Resident 1's record indicated teaching was done on 2/22/20 and 3/7/20 and Resident 1 was able to change the ostomy bag with supervision on 3/10/20. There were no further notes regarding education for Resident 1 and no notes that reflected education given to FM. A review of the IDT Discharge Summary, signed by Resident 1 on 3/14/20, did not include any instructions regarding ostomy care. On 8/27/20 at 11:45 am, SSD provided written instructions given to residents upon discharge but they did not include ostomy care instructions. During an interview on 8/27/20 at 3:20 pm, the DON agreed the family should have been involved in the discharge planning, and more than just having a few questions answered, since Resident 1 was being discharged to FM's home instead of her own home. 3. During an interview on 8/24/20 at 8:45 am, FM stated Resident 1 was only given around three ostomy bags so they didn't have enough supplies to change the bag as often as needed. A review of Resident 1's record and discharge summary did not indicate how many bags, if any, were given to Resident 1 at the time of discharge. During an interview on 8/27/20 at 11:35 am, treatment nurse (TN) stated she thought the extra bags that had been ordered for Resident 1 were given to her at the time of discharge, but she was unable to say how many bags since she did not participate in her discharge. She stated if the bags were being changed every three days, like the physician ordered when Resident 1 was in the facility, then she should have received six bags, since they try to give a two week supply upon discharge.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE