STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARYSVILLE POST-ACUTE	**1617 RAMIREZ STREET MARYSVILLE, CA 95901**

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 interview and record review, the facility did not ensure they provided Resident 1 a timely written notification of a denial notice of payment from her insurance company. This action had the potential for residents not to receive timely denial notifications and instructions on how to appeal the insurances denial for payment. Findings: Resident 1 was interviewed on 2/28/18 at 2:30 pm. Resident 1 stated she was admitted to the facility on [DATE] and on 1/12/18 the facility verbally informed her she had to leave, and that they planned to have a meeting with her. She stated around 1/22/18 the facility, herself, and the Ombudsman (State appointed advocate) had a meeting. Resident 1 stated during this meeting she never received a notice for discharge, or a copy of her insurances denial letter for payment. Resident 1 then stated she was not aware she could appeal her insurance company's decision. Resident 1's record was reviewed on 3/2/18, and showed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 12/8/17 indicated she was mentally intact and required two staff for assistance with transfers. During an interview with the Director of Nurses (DON) on 3/2/18 at 11:56 pm, she stated Resident 1's insurance had sent the facility a denial of payment letter and they had explained to her that she had plateaued (reached her highest level of functioning) with the Physical Therapist (PT). The DON stated Resident 1's insurance would no longer pay for her stay, and she was told she would be responsible for the payment if her insurance company would not cover the costs. A review of all of Resident 1's Physical Therapy Notes indicated the following: Resident 1's start of care for her Physical and Occupational Therapy (PT/OT) services was on 12/3/17. The PT initial assessment indicated Resident 1 was referred to services due to her new decreased strength, functional mobility, and need for increased assistance due to her recent amputation. Transfer training was provided from 12/17 to 1/18/18 five times a week. A review of a PT Encounter Note, dated 1/19/18, indicated Resident 1 was to be discharged from PT because she was independent with her bed mobility, and had no coverage from her Health Maintenance Organization (HMO). The note indicated her last day of coverage was 1/12/18. Resident 1 was then discharged from PT services on 1/19/18 after reaching her .maximum potential . and was instructed to come to the gym to maintain self-maintenance strengthening. Resident 1's Interdisciplinary Team (IDT, a team of professionals that meet to discuss services and plan for residents' care) Notes were reviewed. There was no documentation in the IDT Notes of her insurance denial of payment until 1/23/18 at 3:24 pm when a meeting was held regarding Resident 1's discharge planning. The note quoted Resident 1 as stating she had rights, and she was not going to a homeless shelter. Documentation included Resident 1's insurance company would no longer pay for her stay. The Ombudsman was documented as stating the Business Office Manager (BOM) should have submitted the information (denial letter) to Resident 1 from her insurance company when they received it (seven days ago). The same IDT note additionally indicated that Resident 1 wanted to appeal the insurance decision. On 3/15/18 at 3:15 pm the Social Service Director (SSD) stated she arranges the discharges for the facility. On 3/15/18 at 5 pm, the Business Office Manager (BOM) was interviewed. BOM stated on 1/16/18 at 4:46 pm she received a denial of payment letter from Resident 1's insurance company. She stated although receiving the notice on 1/16/18 the denial letter indicated Resident 1's covered payment had ended on 1/12/18. The BOM stated she could not find a standardized denial letter from Resident 1's insurance company. She stated the denial letter indicated that all parties were notified and she had not confirmed this with Resident 1. She stated she provided the letter to the Administrative staff to present to Resident 1 for the IDT care conference when the Ombudsman came. S he stated the IDT eventually gave her a copy of the denial letter but she did not sign it. She stated she never had Resident 1 sign the denial letter as she did not have the sufficient forms. During an interview and record review with the Administrator (Admin) on 4/13/18 at 9:40 am, he stated the SSD and himself are responsible for discharges and the BOM is responsible for informing the residents of insurance denials. Admin stated they needed to figure out a process to find out if residents had received their denial letters. On 4/13/18 at 11:20 am, BOM stated she never asked Resident 1 if she had received her insurance denial letter. A review of Documentation of Transfers/Discharges policy revised 5/17, directed the facility to ensure proper documentation from social service, nursing and the IDT to provide the appropriate notices to the resident. The notice must notify the resident /and or their representative in writing the reason for the move or discharge.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not develop a timely discharge care plan after the completion of the comprehensive assessment that included needs at discharge. This had the potential for residents mental and psychological needs not to be met with measurable objectives and timetables. Resident 1's discharge care plan was developed on 1/29/18 four days prior to her discharge on 2/2/18 after a length of stay for greater than two months. Findings: A review of Care Plan-Preliminary policy revised 8/06, instructed the immediate care plan would be developed within 24 hours to meet resident's immediate needs. A review of Care Planning- Interdisciplinary Team policy, revised 9/13, instructed a comprehensive care plan would be developed within seven days of completion of the Minimum Data Set (resident assessment). The care plan would contain ongoing interventions associated with identified problems. Resident 1 was interviewed on 2/28/18 at 2:30 pm. Resident 1 stated prior to her admission to the hospital and to the facility she was staying in a motel with a friend, became sick and was not able to get her own home. Resident 1's record was reviewed on 3/2/18, and indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. her first assessment was dated 12/8/17. A review of a Nurse Practitioners (NP) Progress Note dated 12/4/17 at 4:35 pm, indicated Resident 1 had informed the NP that she had nowhere to go after her discharge. The NP documented she would work with the facility Social Worker on this concern. A review of Resident 1's Discharge Care Plan indicated a start date of 1/29/18. The care plan did not include that Resident 1 was admitted with nowhere to go after discharge (homeless). On 3/15/18 at 3:15 pm, the facility Social Service Director (SSD) was interviewed. She stated she does resident discharges, and she knew Resident 1 was basically homeless. She was unable to locate another discharge care plan for Resident 1. She stated she usually does them . about when they are leaving . During an interview and record review of Resident 1's care plans with The Director of Nurses (DON) on 3/15/18 at 11:450 am, she stated Resident 1's discharge care plan was late and did not address her homeless status. The DON stated Resident 1's comprehensive assessment was completed around 12/22/17, and the Social Service discharge plan of care was approximately a month late. She stated it was created prior to Resident 1's discharge.

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.