SECTION 1424 NOTICE

CITATION NUMBER: 03-2627-0014525-F

Date: 10/30/2018 Time: 11:35

Type of Visit : Complaint Investig.

Incident/Complaint No.(s) : CA00533610, CA00524370

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Licensee Name:	Windsor Sacramento Estates, LLC
Address:	9200 West Sunset Boulevard, Suite 725 West Hollywood, CA 90069
License Number:	030000043 Type of Ownership: Limited Liability Company

Facility Name:	Windsor Care Center of Sacramento
Address:	501 Jessie Avenue Sacramento, CA 95838
Telephone:	(916) 922-8855
Facility Type:	Skilled Nursing Facility Capacity: 128
Facility ID:	030000160

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 11/5/18 11:59 p.m.

483.15(e)(1)(2)

CLASS B CITATION -- FAILURE TO READMIT

F206 CFR 483.15 (e) (1) (2) Policy to Permit Readmission beyond Bed-Hold
(e)(1) Permitting residents to return to facility.

A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-

(A) Requires the services provided by the facility; and

(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

(e)(2) Readmission to a composite distinct part. When the facility to which a resident

Name of Evaluator:
Heayoung Quinn
HFEN

Evaluator Signature : [signature]

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : [signature]
Name : Cecilia Binatoira
Title : RN IDON

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

returns is a composite distinct part (as defined in Section 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

The following citation is written as a result of complaints #CA00524370 and #CA00533610. An unannounced visit was made to the facility on 3/8/17 to investigate an allegation of refusal to readmit.

The Department determined the facility failed to readmit Resident 1 after the resident was stable and cleared by the physicians for readmission to the facility from the General Acute Care Hospital (GACH) as of 4/25/18.

This failure resulted in the resident's prolonged hospital stay and increased the potential to cause emotional distress to Resident 1.

Resident 1 was a long term resident in the facility with diagnoses that included an advanced stage of memory problems with behaviors. Resident 1's behaviors were manifested by physical aggressiveness, resistance to care, restlessness, wandering, being intrusive into other's personal space and rooms. Other behaviors included removing his clothing and walking in hallway, gravitating towards others, pushing peers in their wheelchair or Merry Walker (ambulation device and rolling walker), socially inappropriate behaviors of trying to touch females and using profanity.

Review of Resident 1's clinical notes included an Interdisciplinary Note (IDT), dated 10/3/16, indicating Resident 1 was sent out to the GACH emergency department on 10/1/16 for evaluation after being involved in 3 resident to resident altercations over a two day period. The IDT notes documented that the first incident, alleged on 9/30/16, reported by a peer that, "...this Resident [Resident 1] walked by and struck out at co-peer's head." The second incident occurred on 10/1/16 and was documented, "Resident walked by co-peer in hall way and struck out at co-peers back." The third incident was described as, "3rd incident (1/10/16) [sic] -Resident walked by co-peer in hallway and struck out at co-peer to top of co-peers head...He [Resident 1] also has poor impulse control. He is restless and wanders about the hallways and is intrusive into others personal space...Following the 3rd incident Resident was sent out to the acute hospital for evaluation."

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	Review of the GACH clinical record included: An Internal Medicine Daily Progress Note by MD 1 (Medical Doctor 1), dated on 10/11/16, which indicated, "[Resident 1] was in bed enclosure yesterday and this morning, less agitated ...back to SNF [Skilled Nursing Facility] once out of enclosure >24H [more than 24 Hours]" A Psychiatry Consult Progress Note by MD 2 (Psychiatrist), dated 10/11/16, indicated, " ...At this point he appears to be at his baseline level of functioning and is stable for transport back to [Facility Name] from a psychiatric perspective." Clinical Case Management Progress notes, dated 10/11/16-10/16/16, indicated Resident 1's behaviors reoccurred and progressively became more aggressive. The 10/12/16 note indicated, Resident 1 was "...extremely agitated and started yelling out, hitting staff and try [sic] to get out of bed, unable to follow commands, confused" and a "Bed enclosure restraint order initiated." The 10/16/16 note indicated Resident 1, "...hit staff, yelling, cursing. 2 mental health workers and 2 RN [Registered Nurse] assisted pt [patient, Resident 1] back to bed...continues to be agitated forcible pushing furniture in room...continues to attempt to hit staff and cursing, not staying in bed Posey bed [a type of restraint, a hospital bed with enclosed bed canopy] side closed..." An Intensive Case Management Follow Up Note, dated 2/6/17, indicated, "...Looking for placement...pt [Resident 1] remains in a Posey bed and therefore will need a secured facility, wherever it is." An Intensive Case Management Follow Up Note, dated 2/13/17, indicated, "Pt remains with Posey bed, which is considered restraint." In an interview on 3/8/17 at 10:35 a.m., the facility psychiatrist (MD 3), who was also a staff psychiatrist at the GACH, stated Resident 1 was "too violent" for the facility to provide care. The MD 3 stated the resident was a "Danger to others...the facility won't be able to take care of him if he's readmitted." Review of the GACH Clinical Case Management Assessment Note, dated 9/11/17, indicated Resident 1 required a Posey bed, "PT [Resident 1] is currently requiring a Posey bed & belt, which are considered restraints by State Licensing; Therefore, if requiring any form of restraint within a 24 hour period of D/C [discharge], if SNF located, the patient [Resident] would not be able to leave."

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	Review of the GACH clinical record revealed Resident 1 was medically stable and was cleared by the psychiatrist for readmission to the facility beginning 4/25/18. Physician notes included the following: An Internal Medicine Daily Progress Note, completed by MD 4, dated 4/7/18, indicated, "Patient [Resident 1] was admitted for agitation and behavioral problems but is currently calm, non-combative and easily re-directable. Patient currently at baseline and medically stable for discharge to a lockdown facility." An Internal Medicine Daily Progress Note completed by MD 5, dated 4/19/18, indicated "Patient [Resident 1] admitted for agitation and behavioral problems but has been calm, non-combative, and easily re-directable here. Patient currently at baseline and medically stable for discharge to a lockdown facility." A Psychiatry Consult Progress Note completed by MD 6 (Psychiatrist), dated 4/25/18, indicated, "Hospital course complicated by injury to staff in 5/2017 ...Psychiatry was consulted for evaluation and treatment recommendations, has been stable ...Still at baseline, minimally interactive, mostly groaning or mumbling to himself...Posey open and not needing restraints...He is otherwise able to ambulate and enjoys walks down the hallway and is verbally redirectible." Review of an Allscrips Summary (an electronic referral source), dated 5/18/18, indicated the most recent referral notice was sent on 5/11/18, and the "skilled nursing referral was sent to 350 recipients including [facility]. During an interview with the Admissions Assistant on 6/1/18 at 2:50 p.m., she stated Resident 1 was referred for re-admittance to the facility and the facility declined readmission for Resident 1 due to, "no available bed" on 5/11/18. In an interview on 6/1/18 at 11:50 a.m., the Administrator stated the facility was certified for 128 beds but currently 121 beds were available due to the remodeling of the facility. The Administrator stated the facility was in "discharge mode" while building a "behavioral unit" in the facility. Review of the facility admission record between 4/25/18 and 6/1/18 indicated there were 11 total admissions (8 new admissions and 3 readmissions) during that time period. The facility census ranged from 115 to 120 in May, 2018. The DON verified the

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	facility total census for 5/17/18 was 120 including one new admission on that day. Review of the facility 6/2017 policy and procedure, Transfer and Discharge Notice stipulated, "This facility shall permit each resident to remain in the facility, and not transfer or discharge the resident unless: The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility...The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident..." Therefore, the Department determined the facility failed to readmit Resident 1 after the resident was stable and cleared by the Doctor and the Psychiatrist for readmission to the facility from the General Acute Care Hospital (GACH), as of 4/25/18. This violation had a direct or immediate relationship to the health, safety, or security of Long Term Care patients or residents.