STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview and record review, the facility failed to ensure a comprehensive discharge care plan was completed for one of three sampled discharged residents (Resident 2). This failure had the potential to compromise Resident 2 ' s safety on discharge and delay post-discharge care for Resident 2 ' s ongoing health care needs. Findings: Resident 2 was admitted to the facility on [DATE] with diagnoses which included a history of diabetes mellitus type 2 with circulatory complications (occurs when the body is unable regulate blood sugar causing risks for heart attacks, strokes, and other circulatory problems such as poor wound healing), per the facility ' s Admission Record. A review of Resident 2's medical record was conducted. The Minimum Data Set (MDS- assessment tool) dated 1/24/24 indicated that Resident 2 had a moderate cognitive (mental processes that occur in the brain, including thinking, attention, language, learning, memory, and perception) impairment. The MDS section Q indicated that there was no referral to a local contact agency (LCA: to discuss options for post-discharge transition to the community). Resident 2 ' s physician ' s orders dated 2/1/24 included wound care treatments to the right first toe and a discharge order with home health for wound management. On 5/7/24 at 1:42 P.M., an interview and record review was conducted with the social services director (SSD). The SSD could not locate Resident 2 ' s discharge care plan. The SSD stated it was important to update the resident ' s care plan related to discharge, to ensure a safe and appropriate discharge plan. The SSD acknowledged that a discharge care plan was not completed for Resident 2. On 5/7/24 at 1:45 P.M., an interview with the director of nursing (DON) was conducted. The DON stated that if the discharge care plan was not available in Resident 2 ' s chart, that it was missed. The DON stated that her expectations was for Resident 2 ' s care plan to be updated by the SSD and/or the nursing staff to ensure post-discharge plans were appropriate. The DON acknowledged it was important that Resident 2 had a discharge care plan completed for a safe discharge. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedures titled, Discharge and Transfer of Residents, dated February 2018 indicated .Policy . III. When the resident is near a planned discharge, the Interdisciplinary Team (IDT) will Complete a Discharge Summary/ Post Discharge Plan of Care. IV. Nursing Staff will complete a Discharge Summary/Post Discharge Plan of Care for each resident . Based on interview and record review, the facility failed to ensure a comprehensive discharge care plan was completed for one of three sampled discharged residents (Resident 2). This failure had the potential to compromise Resident 2's safety on discharge and delay post-discharge care for Resident 2's ongoing health care needs. Findings: Resident 2 was admitted to the facility on [DATE] with diagnoses which included a history of diabetes mellitus type 2 with circulatory complications (occurs when the body is unable regulate blood sugar causing risks for heart attacks, strokes, and other circulatory problems such as poor wound healing), per the facility's Admission Record. A review of Resident 2's medical record was conducted. The Minimum Data Set (MDS- assessment tool) dated 1/24/24 indicated that Resident 2 had a moderate cognitive (mental processes that occur in the brain, including thinking, attention, language, learning, memory, and perception) impairment. The MDS section Q indicated that there was no referral to a local contact agency (LCA: to discuss options for post-discharge transition to the community). Resident 2's physician's orders dated 2/1/24 included wound care treatments to the right first toe and a discharge order with home health for wound management. On 5/7/24 at 1:42 P.M., an interview and record review was conducted with the social services director (SSD). The SSD could not locate Resident 2's discharge care plan. The SSD stated it was important to update the resident's care plan related to discharge, to ensure a safe and appropriate discharge plan. The SSD acknowledged that a discharge care plan was not completed for Resident 2. On 5/7/24 at 1:45 P.M., an interview with the director of nursing (DON) was conducted. The DON stated that if the discharge care plan was not available in Resident 2's chart, that it was missed. The DON stated that her expectations was for Resident 2's care plan to be updated by the SSD and/or the nursing staff to ensure post-discharge plans were appropriate. The DON acknowledged it was important that Resident 2 had a discharge care plan completed for a safe discharge. The facility's policy and procedures titled, Discharge and Transfer of Residents, dated February 2018 indicated .Policy . III. When the resident is near a planned discharge, the Interdisciplinary Team (IDT) will Complete a Discharge Summary/ Post Discharge Plan of Care. IV. Nursing Staff will complete a Discharge Summary/Post Discharge Plan of Care for each resident .