

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Magnolia Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S Magnolia Ave El Cajon, CA 92020	

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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</p> <p>Based on interview, and record review, the facility failed to provide proper discharge planning to ensure a safe and coordinated discharge for one of three sampled residents (Resident 1) during a complaint investigation.</p> <p>This deficient practice placed Resident 1 at risk for an unsafe discharge and re-hospitalization .</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of visuospatial deficit and spatial neglect following cerebral infarction (trouble with seeing and understanding where things are in space after a brain attack also known as stroke).</p> <p>A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 5/13/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>On 5/21/25 at 11:12 A.M., an interview and record review was conducted with the Director of Rehab (DOR). The DOR stated Resident 1 received rehab services for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for cognition. The DOR stated Resident 1 's prior level of function (PLOF) was independent with ambulation. The DOR stated OT discharge summary dated 5/5/25 indicated:</p> <p>.Pt [patient] has poor functional mobility and requires Max A [maximum assistance: Helper does MORE THAN HALF the effort] .</p> <p>.Poor dynamic standing balance Fair static standing balance .</p> <p>.Pt. will demonstrate improved (good) balance and stability during activities, allowing for safe and independent participation in daily routines .Poor static/dynamic balance .</p> <p>.D/C [discharge] recs [recommendations] .24 hour care and walker with tray .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DOR stated, this would call for care giver training [record review above]. The DOR stated he was unable to find documentation if Resident 1 ' s MD (Medical Doctor) was notified regarding OT recommendations for 24 hour care and did not see documentation if Resident 1 ' s girlfriend (GF) would be the care giver of Resident 1. The DOR stated he was unable to find documented evidence if any care giver training with Resident 1 ' s GF and/or other care giver for Resident 1 ' s care with rehab. The DOR stated Resident 1 ' s GF was supportive and did not indicate if she would be the primary care giver after Resident 1 ' s discharge. The DOR stated caregiving training was important because this would assist with transition of care to home for Resident 1 and would be a safety issue because Resident 1 ' s GF probably would not know how to care for him if it ' s above what she can do. The DOR stated Resident 1 ' s last coverage date (LCD) was issued on 5/12/25 and was discharged on [DATE].</p> <p>On 5/22/25 at 11:39 A.M., an interview and record review was conducted with the Case Manager (CM). The CM stated Resident 1 was able to ambulate with supervision using a walker on 5/2/25 at 300 ft anon 5/9/25 at 90 ft this information was sent to Resident 1 ' s insurance company who gave him a LCD. The CM stated ambulation alone should not be the basis of a safe discharge. The CM stated she did not offer a tray as recommended by OT because this was an out-of-pocket expense that Resident 1 would have probably refused. The CM stated caregiver training and housing would be arranged by the Social Services Director (SSD). The CM stated Resident 1 discharged home without 24 hour care with home health for PT/OT/RN and home health assistant.</p> <p>A clinical chart review was conducted on Resident1 ' s PT discharge summary dated 5/12/25 that indicated . Prior Living Description: Pt reports living in a home with a roommate that most likely will not be able to help with activities if needed .</p> <p>On 5/22/25 12 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON stated the SSD documented that she tried calling Resident 1 ' s GF on May 11, 2025, and May 12, 2025 and was unsuccessful but Resident 1 was able to contact GF that day who stated she would be with Resident 1 on his discharge day. The DON stated on Resident 1 ' s discharge day that his GF was not available.</p> <p>A review on Resident 1 ' s clinical record indicated, no documentation of MD notification for unsuccessful attempts made by SSD to arrange for a safe discharge and OT recommendations for 24 hour caregiver.</p> <p>On 5/22/25 at 12:42 P.M., an interview was conducted with the DON. The DON stated they should have facilitated a safe discharge by making proper arrangements with Resident 1 ' s care giver to ensure a safe discharge plan was in place for care giver training. The DON stated it was important to notify Resident 1 ' s Physician with barriers (OT recommendations for 24 hour care) to discharge and notify appropriate entities to facilitate a safe discharge and prevent re-hospitalization s.</p> <p>A review of the facility's policy and procedure titled ADMISSION, TRANSFER and DISCHARGE undated, indicated, .The Facility shall permit each resident to remain in the Facility, and not transfer or discharge the resident from the Facility unless; .The safety of individuals in the Facility is appropriate because the resident ' s health has improved sufficiently so the resident no longer needs the services provided by the Facility .</p>		