

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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 06/13/2024
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)		
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure a significant change Minimum Data Set (MDS) was submitted timely for 1 (Resident #53) of 18 resident MDSs reviewed. Findings included: A facility policy titled, Policy/Procedure- Resident Assessment Instrument, revised 10/01/2023, specified, The Long-Term Care Facility Resident Assessment Instrument 3.0 (RAI) User's Manual Version 1.18.11 October 2023 will be the source guidance for the RAI Process. A Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated 10/2023, specified, An SCSCA [significant change in status assessment] is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. Further review revealed, The CAAs [care area assessment] completion dated (item V0200B2) must be no later than 14 days after the ARD [assessment reference date] (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for SCSCA were met. An Admission Record revealed the facility admitted Resident #53 on 01/22/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), chronic obstructive pulmonary disease, hemiplegia and hemiparesis (paralysis affecting only one side of the body), and sepsis (infection of the blood stream). An admission MDS, with an ARD of 01/28/2024, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #53 did not receive hospice services. Resident #53's care plan included an undated focus area that indicated the resident had a terminal prognosis due to cerebral infarction. Interventions directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Resident #53's Order Summary Report with active orders as of 06/13/2024 revealed an order dated 05/16/2024 for admission to hospice services. (continued on next page)		

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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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53's hospice services POC [plan of care] Summary, as of 06/12/2024 revealed an order dated 05/16/2024 for admission to hospice services on 05/16/2024 under routine level of care due to cerebral infarction. Resident #53's significant change MDS, with an ARD of 05/29/2024, revealed the assessment was not complete. Further review revealed the section titled Signature of RN [registered nurse] Assessment Coordinator Verifying Assessment Completion was blank. During an interview on 06/13/2024 at 10:14 AM, the MDS Nurse stated the MDS was complete when it was signed by the Director of Nursing (DON). The MDS Nurse stated Resident #53's significant change MDS should have been completed by 05/29/2024. She confirmed the MDS was not completed on time. During an interview on 06/13/2024 at 11:07 AM, the DON stated the MDS was considered complete when she had signed it. The DON stated Resident #53's significant change MDS should have been completed and submitted by 05/30/2024. She added it was not completed on time. During an interview on 06/13/2024 at 12:02 PM, the Administrator stated he expected the MDS to be completed and submitted on time.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 28193 Based on interview, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 (Resident #41) of 18 sampled residents reviewed for MDS accuracy. Findings included: A facility policy titled, Policy/Procedure - Resident Assessment Instrument, updated on 10/01/2023, revealed, 8. Each person completing a section of the MDS attests to its accuracy by affixing his/her electronic signature to that section of the MDS. An Admission Record revealed the facility admitted Resident #41 on 05/19/2024. According to the Admission Record, the resident had a medical history that included cellulitis of left lower limb, local infection of the skin and subcutaneous tissue, and homelessness. An admission MDS, with an Assessment Reference Date (ARD) of 05/24/2024, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact. The MDS indicated the resident did not currently use tobacco. Resident #41's Progress Notes, revealed a note dated 05/23/2024 that indicated a nicotine transdermal patch for smoking cessation was not applied due to the resident was smoking. During an observation on 06/11/2024 at 1:23 PM, Resident #41 was observed outside smoking in the designated smoking area. There was a staff member present, and the resident was able to light and smoke a cigarette safely and independently. During an interview on 06/13/2024 at 10:16 AM, the MDS Nurse stated she was responsible for answering the section of the MDS that asked if the resident had current tobacco use. The MDS Nurse stated that Resident #41 was not marked as a current tobacco user on their admission MDS and that was an inaccuracy on her part. During an interview on 06/13/2024 at 11:17 AM, the Director of Nursing (DON) stated she was responsible for the overall accuracy of the MDS as the Registered Nurse (RN) signer. She stated her expectation was for residents who smoked to be triggered on the MDS. She also stated the MDS should be complete and accurate. During an interview on 06/13/2024 at 12:02 PM, the Administrator stated his expectation was for the MDS to be completed timely and accurate.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 28193 Based on interview, record review, and facility policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level I assessment was coded accurately for 1 (Resident #10) of 3 sampled residents reviewed for PASRR. Findings included: A facility policy titled, Policy/Procedure with a Subject titled PASRR, dated 05/01/2023, revealed, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. The policy further revealed, 2. After admission, the Interdisciplinary Team (IDT), will review follow up determinations for Level I positive, and/or if Level II is required and pending evaluation. 3. An IDT member will determine if a Resident Review (RR) is required. 4. Based upon the final determinations, the facility will ensure proper referral to state agencies for the provision of specialized services to residents with ID/RC (Intellectual disability or Related Condition) or SMI (Serious Mental Illness). 5. Social Services shall contact the appropriate State Agency for referral of specialized care and services as needed. An Admission Record revealed the facility admitted Resident #10 on 03/24/2023. According to the Admission Record, the resident had a medical history that included schizoaffective disorder and bipolar disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/2023, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had diagnoses of schizoaffective disorder and bipolar disorder. Resident #10's hospital History and Physical Note, dated 03/11/2023, revealed, under the Assessment/Plan section of the note, a Problem List included the diagnoses of bipolar disorder and schizoaffective disorder. Resident #10's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 03/29/2023, revealed, under the Section III - Serious Mental Illness - Definition portion, for question 10. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? the answer was marked No, deeming the PASRR Level I as Negative, with No Serious Mental Illness, and a Level II - Not Required. During an interview on 06/13/2024 at 11:03 AM, Social Services (SS) Staff #1, who was also the Admission Coordinator, stated she requested a PASRR from the hospital during the admission process, and it was sent to the facility via an electronic file exchange. She stated she reviewed the PASRR, and if they were deemed positive, the Director of Nursing (DON) would then review the PASRR to start a resident review. She stated if there were issues regarding the diagnoses or status of the PASRR, the DON maintained communication with the state office that generated them. SS Staff #1 further stated Resident #10's PASRR was completed in March 2023, and she did not start in her position at the facility until May 2023. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2024 at 11:07 AM, the DON stated SS Staff #1 requested the PASRR because it was a requirement for admission. The DON stated if there were medications or diagnoses that triggered when she received the PASRR, she reviewed it with the resident's chart and if referrals were needed then she would initiate those referrals. The DON further stated Resident #10's PASRR was incorrect. The DON stated at the time Resident #10's PASRR was generated, the facility did not have a good process in place. She further stated her expectation was for a designee to review the PASRR for accuracy and if there were discrepancies in the clinical documentation, it should be given to her for review. The DON stated if the PASRR was not correct, she would apply for a resident review or a reconciliation until the evaluation was corrected. The DON stated if the resident had a positive Level I PASRR, the facility would start looking for the State to send them a determination letter. During an interview on 06/13/2024 at 12:06 PM, the Administrator stated he understood very little about the PASRR process; however, his expectation was for staff to receive the required documents, and if they were not correct, to get them corrected to be accurate		

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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. 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure a care plan was completed for diuretics for 1 (Resident #53) of 5 sampled residents reviewed for unnecessary medications. Findings included: A facility policy titled, Policy/Procedure- Nursing Administrative with a Subject titled Comprehensive Assessment, revised in 03/2021, specified, All problems, goals, and interventions will be documented in the Resident's Comprehensive Care Plan. An Admission Record revealed the facility admitted Resident #53 on 01/22/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), chronic obstructive pulmonary disease, chronic kidney disease, atrial fibrillation, and hypertension. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2024, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident received a diuretic. Resident #53's Order Summery Report with active orders as of 06/13/2024, revealed an order dated 05/16/2024 for Lasix (furosemide, diuretic) 40 milligram (mg), one tablet as needed for edema, once a day. Resident #53's comprehensive care plan revealed no documentation that a care plan was completed for the use of a diuretic. During an interview on 06/13/2024 at 10:14 AM, the MDS Nurse stated she was the one that should have created a care plan when the order was entered for Resident #53's diuretic. She stated the care plan was needed because it helped the staff to monitor for signs and symptoms of edema. During an interview on 06/13/2024 at 11:07 AM, the Director of Nursing (DON) stated the care plans should be compared to the resident charts and should match. She added that the diuretic should have been care planned for Resident #53.		