STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055954	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Conv Center of San Diego	220 East 24th Street National City, CA 91950

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and facility documents review, the Licensed Nurse (LN) 1 failed to verify a provider's discharge plan related to opioid (powerful pain-reducing medications, an example is hydrocodone/ acetaminophen) medication upon discharge for one of three sampled residents (Resident 1). The lack of communication between the provider and the facility's LNs had the potential for miscommunication with the transition of care to the receiving facility for Resident 1. Findings: On 12/18/24, the Department received a complaint related to resident's discharge. On 12/23/24, an unannounced visit to the facility was conducted. A review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included lumbar fracture (broken vertebrae in the lower back). On 12/23/24, a review of Resident 1's discharge notes completed by Nurse Practitioner (NP, is a healthcare provider who teamed with the attending physician) was conducted. The NP notes dated 10/7/24, indicated, . Patient examined at bedside for discharge evaluation today to board and care (B & C, a residential care option catering to individuals requiring assistance with daily living activities) .Impression and Plan .Acute on chronic left hip OA (sic, osteoarthritis - a degenerative joint disease, in which the tissues in the joint break down over time) with associated pain: pain management in the form of Gabapentin (pain medication) and acetaminophen PRN (sic, pro re nata, which means as the need arises) . On 12/23/24, a review of LN 1's discharge summary notes for Resident 1, dated 10/7/24, indicated, . instructions given to the patient .discharged home .with remaining med [sic, medication] . On 12/23/24, a review of Resident 1's medication list provided to the resident upon discharge included 12 tablets of hydrocodone/ acetaminophen. On 12/23/24 at 2:22 P.M., an interview was conducted with LN 1. LN 1 stated she did not remember Resident 1. (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

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/24 at 2:38 P.M., a joint review of Resident 1's clinical record and an interview was conducted with LN 2. LN 2 stated once discharge was initiated for a resident, the Case Manager (CM) and or the Social Service (SS) was responsible for the start of the process of resident discharge. LN 2 stated for Resident 1, CM conducted the process of resident discharge. Per LN 2, the CM provided the LNs a form for the LNs to fill up which included the discharge plan, where the resident was going, follow up appointment with their primary care physician, any referrals, and the medications the residents were about to take at home or at the receiving facility. LN 2 stated Resident 1 was discharged to a board and care facility. LN 2 stated there was a different form where the LNs indicate the list of medications left then provided the resident a copy and gave the resident or the responsible party the rest of the medications for the residents to take at home or at the receiving facility. LN 2 stated the LNs should have verified to the attending physician whether a resident should continue taking opioid medication upon discharge. Per LN 2, Resident 1 received the 12 remaining tablets of hydrocodone/ acetaminophen for the resident to continue taking at home. On 12/23/24 at 3:17 P.M., a joint review of Resident 1's clinical record and an interview was conducted with LN 3. LN 3 stated she helped LN 1 with documentation during the time of Resident 1's discharge. LN 3 stated LN 1 was the nurse assigned and was responsible for Resident 1's discharge on 10/7/24. LN 3 stated one of the responsibilities of the LN discharging the resident included med instructions to the resident. On 12/23/24 at 4:06 P.M., an interview was conducted with the NP. The NP stated she recalled Resident 1 upon reading Resident 1's history and physical. The NP stated she was at the facility when Resident 1 was discharge. Per NP, Resident 1 was discharged to a B & C facility, and the plan was for mobility assistance not for opioid therapy. Per NP, she remembered Resident 1 had chronic back pain and was managed by acetaminophen. The NP stated she recalled she discharged Resident 1 with acetaminophen and not an opioid medication. The NP stated, I don't believe she discharged with opioid, I discharged her with Tylenol (acetaminophen). On 12/23/24 at 4:48 P.M., a joint review of Resident 1's med list and an interview were conducted with the Director of Nursing (DON). The DON stated the expectation was for the LNs to verify the discharge plan for the resident, review, reconcile, verify the meds, and get an order from the provider that may send the remaining meds with the resident especially for opioid medications for safety purposes. A review of the facility's policy titled, Transfer or Discharge - Facility Initiated, revised October 2022, indicated, .Policy Interpretation and Implementation . 2 .b. discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community . Documentation of Facility-Initiated Transfer or Discharge .h. Disposition of medications . The policy did not indicate verification of opioid medications to the provider.