

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Mesa Verde Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 661 Center Street Costa Mesa, CA 92627	

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview and medical record review, the facility failed to ensure one of three sampled residents (Resident 1) was properly discharged from the facility. This failure had the potential to place Resident 1 at risk for not receiving the proper care after the discharge.</p> <p>Findings:</p> <p>Closed medical record review for Resident 1 was initiated on 2/18/25. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Resident 1 had a diagnosis of type two diabetes mellitus with hyperglycemia.</p> <p>Review of Resident 1's H&P examination dated 4/24/24, showed Resident1 had the capacity to make medical decisions.</p> <p>Review of Resident 1's Order Summary Report showed the following orders:</p> <ul style="list-style-type: none"> - dated 1/8/24, give 15 units of Humalog insulin injection before each meal that contains carbohydrates - dated 1/9/24, Humalog Injection Solution (Insulin Lispro) inject as per sliding scale - dated 10/15/24, Trulicity Subcutaneous Solution (Dulaglutide), Inject 4.5 mg subcutaneously one time a day every Tuesday - dated 11/12/24, Basaglar Kwikpen Subcutaneous Solution (Insulin Glargine), inject 60 unit subcutaneously one time a day - dated 12/23/24, Humalog Injection Solution (Insulin Lispro), inject 24 unit subcutaneously three times a day - dated 2/4/25, showed an order may discharge tomorrow to home with current meds with home health PT/OT/RN to follow up with PCP in one to two weeks. <p>Review of Resident 1's Discharge Planning Review Form (undated) showed the following information:</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - reason for discharge was going home with friend - in caregiver responsibilities, yes was checked for will resident have a caregiver after discharge - in discharge goal barriers, medical and medication managements were checked - in medication reconciliation, yes was checked for current reconciled medication list provided to the patient and/or caregiver - in performing special treatments/procedures, showed in actual upon discharge the family/friend support and professional assistance were checked. - in discharge information, in medications sent with resident, showed a comment of see attached discharge/transfer report. <p>However, the facility was unable to provide the discharge/transfer report to show the following:</p> <ul style="list-style-type: none"> - teaching/training was provided to the resident and resident's caregiver - list of Resident 1's medications were provided to the resident and resident's caregiver <p>Review of Resident 1's Progress Note dated 2/5/25 at 1220 hours, showed Resident 1 was discharged home via transport.</p> <p>On 2/19/25 at 0954 hours, an interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 was asked about the protocol for discharge. LVN 1 stated there should be a physician's order for the discharge, the staff should prepare all the paperwork, go over the medication list, provide the teaching or training regarding the medications, and provide the remaining medications. LVN 1 stated the medications were given to Resident 1. LVN 1 verified there was no teaching or training provided because Resident 1 would not have been able to remember or understand the teachings. LVN 1 also stated Resident 1 was not capable of administering the medications. LVN 1 was asked if the resident's caregiver was with the resident or was called during the discharge. LVN 1 stated Resident 1 was discharged via transport and the resident's caregiver was not called during the time of discharge.</p> <p>On 2/19/25 at 1152 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON was asked about the protocol for discharge. The DON stated the resident should be educated on the medications, provide the medication list, assess the capability to administer the medications and should have a follow-up appointment with the primary care physician. The discharging nurse should document the remaining medications were sent to the resident including the list of medications, and the resident and resident's caregiver were educated or trained on the medications that were provided. Furthermore, the DON stated Resident 1 needed assistance with the medication administration. Resident 1 could not self-administer the insulin injections. The DON confirmed it was not a safe discharge for Resident 1 because there was no teaching or training provided to the resident and resident's caregiver. The responsible person for Resident 1 was not in attendance during the time of discharge.</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview and medical record review, the facility failed to provide and document sufficient preparation to ensure the safe and orderly discharge for one of three sampled residents (Resident 1).</p> <p>* Resident 1 was discharged with home health services; however, there was no documentation if the home health agency referral was arranged prior to the discharge. This failure placed Resident 1 at risk for not receiving the proper care after the discharge.</p> <p>Findings:</p> <p>Closed medical record review for Resident 1 was initiated on 2/18/25. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's Order Summary Report showed an order dated 2/4/25, may discharge to home with current medications with home health PT/OT/RN to follow up with the PCP in one to two weeks.</p> <p>Review of Resident 1's Progress Note dated 2/3/25 at 1634 hours, showed the SSD had spoken with Resident 1 regarding the discharge and would set up for home health services as ordered.</p> <p>Further review for Resident 1's medical record failed to show a referral was sent to the home health provider.</p> <p>On 2/19/25 at 1314 hours, an interview and concurrent closed medical review was conducted with the SSD. The SSD was asked for the documentation of the referral to home health services. The SSD was unable to provide documentation for the home health services referral.</p> <p>On 2/19/25 at 1340 hours, the Administrator and DON acknowledged the above findings.</p>		