STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056401	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Hills Post Acute Care	3680 Reynard Way San Diego, CA 92103

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one of three sampled residents (Resident 1) to return to the facility following a hospitalization. In addition, the facility failed to offer a bed hold to Resident 1 per facility policy.As a result of this failure, Resident 1 had the potential to not receive continuity of care, prolonged Resident 1's hospital stay unnecessarily, and violated Resident 1's rights to return to the facility. Findings:During a record review, the document titled admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a movement disorder that worsens over time), and type 2 Diabetes (a condition where the body cannot effectively use the insulin it makes).According to the MDS (Minimum Data Set- a federally mandated assessment tool), dated 3/23/26, Resident 1 had a BIMS (Brief Interview for Mental Status- a tool to assess thinking skills) of 14, which indicated Resident 1 had intact cognition.During an interview with Licensed Nurse (LN) 1 ON 6/18/26 at 9:12 A.M., LN 1 stated on 6/15/26, Resident 1 was transferred to an acute care hospital for being verbally aggressive, and for waving a pair of bandage scissors at a staff member. LN 1 stated He didn't want to give us the scissors so we called 911 and he was taken on a 5150 [a 72-hour involuntary psychiatric hold used when an individual experiences a mental health crisis].During a telephone interview with Certified Nursing Assistant (CNA) 1 on 6/18/26 at 11:08 A.M., CNA 1 stated he was Resident 1's assigned nursing assistant on 6/15/26. CNA1 stated on 6/15/26, Resident 1 requested a shower when CNA 1 was getting ready to provide care to another resident. CNA 1 stated when he told Resident 1 he could not shower until later that day, Resident 1 became verbally aggressive. Per CNA 1, [Resident 1] called me lazy, and all the Spanish [curse] words. CNA 1 stated while Resident 1 was sitting in bed, he observed Resident 1 wave a pair of bandage scissors in the air. The CNA stated Resident 1 was transferred out of the facility following the incident.During a record review of the acute hospital document titled Hospital Medicine Progress Note dated 6/18/26 at 10:11 A.M., the note indicated, [Resident 1] with depression presenting after behavioral outburst at SNF [Skilled Nursing Facility].patient now calm, cooperative, and stable without recurrence of agitation.Psychiatry consulted on 06/15/2026- recommended lifting 5150.return to facility. The document further indicated, Patient medically stable for discharge but unable to discharge due to lack of accepting SNF, prior facility declined readmission due to behavioral concerns, no family support for home discharge.During a concurrent interview and record review with the Director of Nursing (DON) on 6/18/26 at 11:33 A.M , the DON stated on 6/15/26 the facility was notified that Resident 1 was medically cleared to return to the facility. The DON stated the facility refused to allow Resident 1 to return. The DON further stated on 8/20/25, during a similar incident of aggression with another staff member, Resident 1 was sent to the hospital for behavior management. The DON stated Resident 1 was accepted back to the facility after being medically clear, Because we had to [take him back].During a follow-up telephone interview with the DON on 6/26/26 at 12:33 P.M., the DON stated residents should be offered a bedhold prior to transfers, or within 24 hours of a transfer. The DON stated bed holds were important, to ensure a resident can return to the facility, if appropriate. During (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a review of the facility's policy titled Admission, Transfer and Discharge revised 11/2016, the policy indicated, A physician shall document if the transfer or discharge is necessary because the safety of individuals in the Facility is endangered due to the clinical or behavioral status of the resident OR because the health of individuals in the Facility would otherwise be endangered.It the Facility determines that a resident, who was transferred with an expectation of returning to the Facility, cannot return to the Facility, this constitutes a discharge and this policy shall apply. Therefore, a refusal to readmit the resident to the Facility is considered a discharge, and the requirements of 42 CFR Section 483.15 in terms of documentation, notice before transfer, and orientation for transfer/discharge apply. The policy did not offer guidance regarding allowing a resident to return to the facility following hospitalization.During a review of the facility's undated policy titled Bed Hold, the policy indicated, It is the policy of this facility to inform the resident, or the resident's representative, in writing, of the right to exercise the bed hold provision of seven (7) days, upon admission and before transfer to a general acute care hospital or before the resident goes on therapeutic leave.