| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295045 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Torrey Pines Post Acute and Rehabilitation | 1701 S. Torrey Pines Drive<br>Las Vegas, NV 89146 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a resident was safely discharged to a facility which could meet the care needs of the resident for 1 of 5 sampled residents (Resident 2). The deficient practice had the potential to result in the resident's care needs not being met. Findings include:Resident 2 (R2) was admitted [DATE], readmitted [DATE], with diagnosis including schizoaffective disorder bipolar type, psychosis not due to a substance or known physiological condition, and manic episode. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three (severe cognitive impairment). Disorganized thinking behavior was present, fluctuated, changed in severity.A Care Plan revised 06/17/2025, documented R2 had a behavior problem related to, among others, irritability and anger, impulsiveness, emotional liability, violent behavior, restlessness, agitation, auditory hallucinations, bizarre behaviors, paranoid, labile, racing thoughts, uncooperative, anxious delusion, erratic behavior, dysmorphic mania, anger outburst, tendency to spit, kick, and bite. Interventions included providing 1:1 supervision.An MDS assessment dated [DATE], Section GG, Functional Abilities, documented R2 needed partial assistance from another person to complete any activities. R2 was dependent for indoor mobility, a helper completed all the activities for the resident. Functional cognition stated R2 needed partial assistance from another person to complete any activities. R2 was dependent for eating, and toileting hygiene was substantial/maximal assistance. An Interdisciplinary Discharge summary dated [DATE], documented resident was discharged to a group home. The Activities section documented R2 exhibited behaviors and required a one-on-one sitter.A Social Service Note dated 07/11/2025, documented a placement coordinator/owner assessed R2, accepted the resident, and provided the facility address. R2 was discharged to the accepting facility. Approximately 30 minutes after discharge, the placement coordinator/owner informed the facility that upon arrival, under one-on-one supervision, the resident became agitated, yelling and broke the television.On 11/18/2025 at 12:15 PM, the Social Service Assistant/Discharge Coordinator stated R2 was discharged to an independent living facility. The Social Service Assistant/Discharge Coordinator acknowledged R2's discharge was an unsafe discharge because R2 was sent to an independent living facility and R2 was dependent on others for care.On 11/18/2025 at 12:20 PM, the Assistant Administrator stated R2's discharge was inappropriate based on R2's needs and R2 was not appropriate for an independent living facility. The Director of Nursing was present during the interview and concurred with the statement made by the Assistant Administrator.On 11/18/2025 at 1:45 PM, the owner of the independent living facility indicated the facility could accommodate five residents. There was a caregiver who was expected to provide supervision but not expected to provide assistance with activities of daily living (ADLs). The facility owner recalled R2 was admitted to the facility on [DATE]. The owner denied coming to the facility to assess if R2 was suited for independent living but rather, R2 was accepted based on the trust relationship the owner had with the discharging facility. The owner indicated the independent facility did not admit residents who required assistance with ADLs or behavior monitoring. R2 displayed disruptive behaviors during the stay, was throwing stuff and hitting others so the owner had to call 911 and R2 was transferred to a hospital because the level of care R2 needed could not be provided by the independent living facility. The owner stated R2's discharge by the facility to the home (independent living) was inappropriate. A facility policy titled Discharge Process undated, stated information provided to the receiving provider must include at a minimum all necessary information, and any other documentation to ensure a safe and effective transition of care.Complaint 2573776 |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a resident with severe cognitive impairment received a competency assessment to determine decision-making capacity and the need for a guardian or representative for 1 of 5 sampled residents (Resident 2). The deficient practice had the potential for a severely cognitive impaired resident to not understand or make an informed decision on the care and treatment being provided.Findings include:Resident 2 (R2) was admitted [DATE], readmitted [DATE], with diagnosis including schizoaffective disorder bipolar type, psychosis not due to a substance or known physiological condition, and manic episode.A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three (severe cognitive impairment). Disorganized thinking behavior was present, fluctuated, changed in severity.R2's profile in the electronic medical record documented R2 was responsible party.A Psycho-Social Assessment Form dated 06/25/2025, Admission, documented possible discharge plan to another facility, anticipated long term care, responsible party self, no advanced directives, severely impaired decision making skills regarding tasks of daily life. Additional comments included no relative resources available, no regional psychiatric facility placement available. R2's medical record lacked documented evidence of a Power of Attorney (POA) or guardianship documentation.A Social Services Note dated 06/24/2025, documented the regional psychiatric facility was not able to take R2 back. A suggestion was made to contact a service coordinator to look for an appropriate placement for R2. An Interdisciplinary Discharge summary dated [DATE], documented resident was discharged to a group home.A Resident Notice of Transfer or discharge date d 07/01/2025, documented resident would be discharged from the facility on 07/11/2025. The reason for the transfer or discharge was marked: as per you/and your family request. The signature line of the form read verbal consent from R2, dated 07/11/2025.On 11/18/2025 at 12:15 PM, the Social Service Assistant/Discharge Coordinator explained the discharge process included to ensure resident's needs would be met at the new facility. The Social Service Assistant/Discharge Coordinator stated R2 was followed by a regional psychiatric facility which dropped R2 and was no longer involved or returning phone calls. The Social Service Assistant/Discharge Coordinator acknowledged, due to R2's cognitive impairment R2 needed a legal representative and did not have one. The Social Service Assistant/Discharge Coordinator stated R2 could not make their own decisions and acknowledged R2 was discharged to an independent living facility. The Social Service Assistant/Discharge Coordinator acknowledged a competency assessment should have been completed for R2 to assess the need for a guardian and explained did not have knowledge of the process for guardianship, for residents with severe cognitive impairment.On 11/18/2025 at 12:20 PM, the Assistant Administrator explained a competency evaluation for a resident with a BIMS score of three and no familial support should have been completed for R2, and acknowledged the facility failed to do a competency evaluation for R2.On 11/18/2025 at 12:38 PM, a Physician Assistant (PA), recalled the R2 was admitted with psychosis, mainly had schizoaffective issues and was referred to a psychiatrist. The PA reported R2 was stable some days, but it was back and forth. R2's behavior was unpredictable. The PA confirmed R2 could not make their own decisions and therefore needed a POA, guardianship or representative.A facility policy titled Assessing Resident's Mental Capacity undated, documented if a resident was identified having diagnosis of dementia or impaired cognition, the resident would be referred to the psychiatrist to determine if the resident had the capacity to make informed decisions regarding medical care, financial matters, and daily living activities. In the absence of surrogate or responsible party, the facility would follow state specific laws on guardianship and consent.Complaint 2573776 |