

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/14/2024
NAME OF PROVIDER OR SUPPLIER Pacific Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1323 17th Street Santa Monica, CA 90404	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</p> <p>Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer and Discharge was provided to the resident as soon as practicable for one out of the three sampled residents (Resident 1). The facility also failed to provide documented evidence that indicated that the State Long Term Care Ombudsman (public advocate) was notified that Resident 1 was transferred discharged from Skilled Nursing Facility 1 (SNF 1 - a type of inpatient facility that provides short or long-term skilled nursing care, and rehabilitation services to patients).</p> <p>This deficient practice denied the residents additional protections from being inappropriately discharged and caused Resident 1 to have feelings of anxiety.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts. It's characterized by a depressed mood, loss of interest, and other symptoms that last for at least two weeks), chronic obstructive pulmonary disease (COPD- is a common lung disease that makes it difficult to breathe, and essential hypertension (high blood pressure that is not caused by another disease).</p> <p>A review of the Minimum Data Set (MDS - a standardized comprehensive assessment and screening tool), dated 7/16/2024, indicated Resident 1 was cognitively intact (when someone has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The same MDS indicated Resident 1 required supervision or touch assistance and partial/moderate assistance for Activities of Daily Living (ADLs - toileting hygiene, shower/bathe, upper & lower body dressing, and personal hygiene).</p> <p>During a review of a physician's order dated 7/22/2024 at 1:11 pm, indicated, may discharge [Resident 1] to SNF 2 with hospice evaluation (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life).</p> <p>During a review of the facility's Social Services Director note dated 7/22/2024 at 1:37 pm, indicated Note Text: SSD WAS INFORMED BY RESIDENT THAT SHE INTENDS TO LEAVE FACILITY ON 7\22\24 PER REQUEST AND TRANSFER TO [SNF 2].</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the form titled NOTICE OF TRANSFER/DISCHARGE, dated 7/22/2024, indicated to transfer Resident 1 to another SNF and that the transfer/discharge was necessary for the following reason:</p> <ul style="list-style-type: none"> - The transfer or discharge is necessary for your welfare and your needs cannot be met in the facility. <p>During an interview with Resident 1 on 9/14/24 at 10:01 am, Resident 1 stated that she had been in SNF 1 for over 2 years and considered it home. Resident 1 confirmed that she sometimes complained about some things but that did not mean that she wanted to move out. Resident 1 stated that she felt like the administration retaliated against her because she was vocal about her needs and felt that that was the reason why they discharged her in a hurry. Resident 1 stated that she had never asked any staff for discharge because moving was very disruptive. Resident 1 started sniffing in between words and stated that the whole thing (discharge) caused her anxiety to talk and think about.</p> <p>During an interview with SNF 1 SSD on 9/14/24 at 11: 11 am, the SSD stated that she was not aware about Resident 1's discharge until the day of her (Resident 1) discharge on 7/22/2024. The SSD stated that Resident 1 asked the SSD to see Resident 1 in the resident's room and informed the SSD that she [Resident 1] was going to a different SNF. The SSD admitted that she was responsible for informing the Ombudsman as soon as possible after the facility was aware about Resident 1's discharge to ensure that the ombudsman can investigate if the discharge is appropriate or not. The SSD stated that she was aware that the Discharge Planner (DP-a healthcare professional who helps patients transition from a hospital to their home or another care setting) was looking for placement with other facilities weeks prior. The SSD stated that she notified the ombudsman on the day Resident 1 was discharged to SNF 2.</p> <p>During an interview with the DP on 9/14/24 at 11:24 am, the DP stated that sometime in July, the DP asked Resident 1 if she would like to be discharged to a different facility of which Resident 1 had agreed. The DP stated that he worked with an outside transfer coordinator (a health care personnel who helps coordinate transfers between facilities) and found placement at a different SNF on 7/22/2024. The DP stated he then informed Resident 1 that there was a bed and Resident 1 agreed to the transfer. The DP confirmed that there was no documented evidence of any discussions with Resident 1 requesting for a discharge. The DP was unable to verbalize the importance of informing the Ombudsman about planned discharges.</p> <p>During a concurrent interview and record review of Resident 1's chart with the Director of Nursing (DON) on 9/14/24 at 11:47 am, the DON stated that Resident 1 constantly spoke about discharging to another SNF. The DON stated that the DP had started working on finding a bed with different facilities until one day (7/22/24) when Resident was told that there was an open bed at the SNF she was discharged to, of which Resident 1 said that the resident would go. The DON stated and admitted that when a resident verbalizes desire to discharge, it must be documented in the resident's medical chart. The DON confirmed and stated that there was no documented evidence that the resident expressed the desire to be discharge prior to 7/22/2024.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedures (P&P) titled Discharge Planning Process, reviewed 4/17/2024 indicated, It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The procedure included the following:</p> <ul style="list-style-type: none"> - The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle, and as needed. <ul style="list-style-type: none"> a. Initial information and discharge goals will be included in the resident's baseline care plan. b. Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care. - The evaluation of the resident's discharge needs, and discharge plan will be completely documented on a timely basis in the clinical record. - Education needs, as identified in the discharge plan, will be provided to the resident and/or Family member prior to discharge. 		