STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poway Healthcare Center	15632 Pomerado Road Poway, CA 92064

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to ensure resident records for a resident who left the facility against medical advice (AMA) was accurate and complete for one of two residents (Resident 5) reviewed for complete medical record when: 1. There was no documentation regarding Resident 5 ' s AMA and physician notification. 2. The hospital discharge medication list for Resident 5 was not accurately transcribed. These failures had the potential to cause miscommunication among care providers affecting residents ' treatment and safety, and use of unnecessary medication for the residents. Findings: On 10/10/24 at 9 A.M., an unannounced onsite visit at the facility was conducted related to a complaint. 1. Resident 5 was admitted to the facility on [DATE] with diagnoses including hepatic encephalopathy (brain dysfunction due to liver disease) according to the facility ' s Admission Record. During a review of progress notes (PN) for Resident 5 dated 9/28/24 at ., the PN indicated, .AMA. The PN did not have information regarding events leading to the AMA and there was no documented physician notification. An interview and concurrent record review of Resident 5 ' s progress notes was conducted with the social service director (SSD) on 10/10/24 at 11:34 A.M. The SSD stated she and the facility ' s case manager were assigned to coordinate discharge planning for resident. The SSD reviewed the PN for Resident 5 and stated the PN for Resident 5 indicated, .9/27/24 .Pt [patient] reported to this SN (skilled nurse) that she had an uncomfortable conversation with Dr. [NAME] at bedside early in the morning . The SSD stated the PN on 9/27/24 did not indicate the incident of Resident 5 leaving AMA or physician notification. The SSD stated the progress notes should have a reason why Resident 5 requested to leave AMA, what the facility can address, educate Resident 5 of risks and a physician notification. The SSD further stated it was important to have complete documentation for communication purposes and to know what transcribed on 9/27/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 11:57 A.M. a concurrent record review and interview was conducted with licensed nurse (LN) 3. LN 3 stated on 9/27/24 he saw Resident 5 walk out of her room carrying some of her belongings. LN 3 stated he walked with Resident 5 to the lobby and Resident 5 sat on a chair. LN 3 stated he was notified by Resident 5 that she was ready to go home, and her wife will take care of everything. LN 3 reviewed Resident 5 ' s PN and stated he did not document the conversation with Resident 5 and that Resident 5 left the facility AMA. LN 3 further stated there was no physician notification documented. During an interview and concurrent record review on 10/10/24 at 12:15 P.M. with registered nurse supervisor (RNS), the RNS stated she was at the back station when the director of staff development (DSD- a licensed nurse certified for staff training) notified her that Resident 5 wanted to leave. The RNS stated she went to the front station and saw Resident 5 at the nurse ' s station. The RNS stated Resident 5 told her she was leaving because she can walk and take care of herself. The RNS reviewed Resident 5 ' s PN. The RNS stated she did not document the conversation with Resident 5 and there was no physician notification documented. The RNS stated a complete documentation was needed for reference. The RNS further stated if documentation was not complete, there will be no clear picture of what happened to the resident. 2. During a review of Resident 5 ' s hospital record titled, Discharge Summary, date 9/25/24, the discharge summary indicated a list of medications for Resident 5 upon discharge from the hospital. On page four through six of the discharge summary titled .Discharge Medications . Discontinued Medications . indicated, . spironolactone (a medication that helps the body get rid of excess fluid and salt by having an increased release of urine) 25 mg (milligram) tablet . Page 23-24 of the discharge summary indicated, .spironolactone . 25mg . 9/19/24 0904 (9:04 A.M.) Held by provider .9/19/24 0930 (9:30 A.M.) Dose Auto Held .9/20/24 0900 (9:00 A.M.) Dose Auto Held . 9/21/24 0900 Dose Auto Held . 9/22/24 0900 Dose Auto Held . A review of the facility ' s physician ' s orders for Resident 5 was conducted. The facility ' s physician ' s orders titled, Order Summary Report, indicated, . Active Orders As Of: 09/25/24 . Spironolactone Oral Tablet 25 MG . Give 1 tablet by mouth one time a day . A telephone interview conducted on 10/11/24 at 1:07 p.m. with the RNS to verify Resident 5 ' s admission orders and hospital discharge medications. The RNS stated she did not know how to view admission orders for Resident 5 in the electronic medical record because Resident 5 was already discharged from the facility. A telephone interview was conducted on 10/11/24 at 1:30 p.m. with the DSD. The DSD stated she had the copies of the hospital discharge summary and admission orders for Resident 5.The DSD stated licensed nurses were responsible for reviewing residents ' medications from the hospital and then transcribe them as admission orders at the facility. The DSD stated she reviewed the copies of Resident 5 ' s hospital discharge summary and Resident 5 was taking spironolactone at the hospital. The DSD stated she did not see the discontinued medication list on the discharge summary. An interview with the Director of Nurses (DON) was conducted on 10/10/24 at 3:13 P.M. The DON stated it was important to provide a proper discharge for residents and document in the resident ' s record as evidence of conversation with the resident and the physician. The DON further stated DON stated medications were reconciled upon resident ' s admission to the facility to avoid errors and ensure accuracy of medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure (P&P) titled, Discharging a Resident without a Physician ' s Approval, dated October 2022 was conducted. The P&P indicated, . Should a resident, or his or her representative (sponsor), request an immediate discharge, the resident ' s attending physician is promptly notified . During a review of the facility ' s P&P titled, Charting and Documentation, dated July 2017, the P&P indicated, . The medical record should facilitate communication between interdisciplinary team [IDT: team members with various areas of expertise who work together toward the goals of their residents] regarding the resident ' s condition and response to care . The following information is to be documented in the resident medical record . Events, incidents or accidents involving the resident . A review of the facility ' s policy and procedure (P&P) titled, Reconciliation of Medications on Admission, dated July 2017 was conducted. The P&P indicated, . Purpose . to ensure medication safety by accurately accounting for the resident ' s medications, routes and dosages upon admission . Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications .