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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555427	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean View Post Acute	1980 Felicita Road Escondido, CA 92025

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to appropriately discharge one of one resident (Resident 3) with elopement risk reviewed for discharge planning when; 1. There was no documentation regarding Resident 3's elopement risk and the appropriateness of a discharge to an independent living facility and, 2. A discharge care plan was not developed. As a result, Resident 3 was readmitted to the hospital. Findings: Resident 3 was admitted to the facility on [DATE] with the diagnoses including dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) and repeated falls according to the facility's Admission Record. During a review of the physician's history and physical (H&P) admission note dated 2/7/24, the H&P indicated .patient resides at Board and Care (place to live that provides food and personal care). Patient was wandering and went missing for several days. He was found by local police and brought in the hospital and placed on 5150 hold (when a person is a danger to self or others is detained for 72 hours in a psychiatric hospital) . A review of Nurses Progress Note (NPN), dated 3/9/24, at 4:30 P.M. indicated, The resident was observed by staff ambulating on the walkway near Felicita Road close to traffic. Staff feared he may inadvertently wander into traffic . Further review of NPN dated 3/21/24, 12:10 P.M. indicated Resident 3 was discharged to an independent living facility (ILF-place to live for people who do not need assistance with walking or personal care). During an interview on 4/17/24, at 10:15 A.M. with the facility administrator (ADMIN), the ADMIN stated the interdisciplinary team (IDT-team members with various areas of expertise who work together toward the goals of their residents) discussed residents' discharge plans with social services to assist with home health needs. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Ocean View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1980 Felicita Road Escondido, CA 92025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and concurrent record review on 4/17/24, at 11:44 A.M. with the assistant director of nurses (ADON) was conducted. The ADON stated the IDT included discharge planner, social services, case manager, minimum data set nurse (MDS- nurse who assessed and evaluated the quality of care being given to long-term care residents), ADON or director of nurses, administrator, and rehab staff. The ADON reviewed Resident 3's progress notes (PN). The ADON stated there was no IDT documentation regarding the decision for Resident 3 to be discharged to an ILF. The ADON further stated the case manager, social services or nursing staff should have documented if Resident 3 was appropriate for an ILF. After the ADON's record review on 4/17/24, at 12:18 P.M., the ADON stated she did not attend the IDT meeting regarding Resident 3. The ADON stated if she attended, she would have questioned if the ILF was safe for the resident because Resident 3 had histories of elopements. An interview and concurrent record review was conducted on 4/17/24, at 12:31 P.M. with the social service director (SSD). The SSD reviewed Resident 3's records and stated he did not find IDT notes regarding decision for Resident 3 to be discharged to an ILF. The SSD further stated he should have documented the IDT's decision, family discussion and the income criteria for an ILF. During an interview and concurrent record review on 4/17/24, at 12:41 P.M. with the ADON, the ADON reviewed care plans for Resident 3. The ADON stated there was no care plan regarding Resident 3's discharge planning. The ADON further stated there should have been a care plan to know the plan for Resident 3's discharge. An interview on 5/7/24, at 1:08 P.M. with the ADON was conducted. The ADON stated it was important to document discharge plans for a resident to ensure everyone was aware of discharge and a care plan was expected to be completed for everyone to be aware of the details of discharge planning. A review of the facility's policy and procedure (P&P) titled, Discharge Planning Process, dated 12/19/22 was conducted. The P&P indicated, .5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/or resident representative . An active individualized discharge care plan will address .discharge destination, with assurances the destination meets the resident's health/safety needs .caregiver/support person availability .The facility will document any referrals .The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record .