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	09/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46247 Based on interview and record review, the facility failed to prevent a hazardous situation when supervision was not provided for one resident (1) during an outpatient appointment and his whereabouts were unknown. This deficient practice placed Resident 1 at increased risk of injury when Resident 1 was found, sitting in the sun, outside the outpatient appointment location by a bystander and sent to the hospital. Findings: Resident 1 was admitted to the facility on [DATE] with a diagnosis of a fracture of the right femur (broken right upper leg bone) and unspecified dementia (a loss of mental functioning including, remembering and reasoning) per the facility's admission record. A review of Resident 1's physicians orders indicated, Resident 1 had an outpatient follow-up appointment with an orthopedist (a medical specialist who focuses on injuries and diseases affecting the musculoskeletal system (bones, muscles, joints and soft tissues), on 9/5/24 at 10:45 A.M. On 9/23/24 at 2:45 P.M., an interview was conducted with the social services director (SSD) at the facility. The SSD stated social services oversaw setting up transportation and escorts for residents who needed to attend outside appointments at the facility. The SSD stated social services fills out a paper document that indicates the following: the reason for the appointment, where the resident will be going, who is transporting the resident, if the resident needs a companion and who that companion will be, and a pickup and return time. The SSD stated the social services assistant (SSA) was contacted on 9/5/24 by the transportation company who stated they could not find Resident 1 at the orthopedist office when they went to pick up the resident. The SSD stated he spoke with the orthopedist office who reported Resident 1 left the facility, and was described as upset, after the appointment was over. (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 09/23/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 3:01 P.M a concurrent interview and record review of the facility's transportation record for Resident 1 was conducted with the SSD and the SSA. The SSA stated he was responsible for filling out the paper transportation document for Resident 1's appointment at the orthopedist on 9/5/24. The SSA stated he assumed Resident 1's responsible party (RP) was going to accompany Resident 1 to the orthopedist appointment on 9/5/24. The SSA stated he did not confirm the plan for the RP to accompany the Resident the morning of the appointment. The SSA stated the transportation company picked up Resident 1 for the orthopedist appointment on 9/5/24. The SSA stated the transportation company returned to the facility without Resident 1 and stated the Resident could not be located at the orthopedist ' s office. A review of the document titled, Transportation, dated 9/5/24, indicated, the resident required a companion for the appointment but the section that indicated where the RP would meet the resident at the destination was left blank. The SSA stated they were notified by the RP and the orthopedist office the resident was found lying in his wheelchair in the sun by someone outside the building and the resident was sent to the hospital. The SSD and SSA acknowledged not confirming the Resident 1 ' s RP as an escort to the appointment increased the risk of Resident 1 being placed in an unsafe situation. On 9/23/24 at 3:22 P.M., an interview and record review were conducted with licensed nurse (LN) 1 at the facility. LN 1 stated it was the expectation that nursing document transportation to and from outside appointments in the progress notes. LN 1 stated the following should be documented in the progress notes: pickup time, type of appointment, type of transportation, if traveling with a wheelchair or gurney and if an escort was needed. LN 1 stated a second progress note indicating the time of the resident ' s return to the facility and any new orders should be documented in the electronic health record. A review of Resident 1's progress notes was conducted with LN 1. LN 1 acknowledged there was no progress note indicating how, when or who accompanied Resident 1 to his orthopedic appointment on 9/5/24. LN 1 stated residents who are not independent or need assistance should have supervision at an outside appointment to ensure they don ' t' get lost and wander or experience an accident or injury. On 9/23//24 at 3:59 P.M., a concurrent interview with the director of nursing (DON) and the administrator (ADMIN) was conducted. The DON stated social services was responsible for setting up transportation and escorts to appointments. The DON stated if a resident has an outside appointment and has dementia or other dependent needs, social services should confirm that a family will accompany the resident to the appointment. The DON stated if family is not available to accompany the resident to the appointment, the facility will provide an escort. The ADMIN and DON acknowledged that Resident 1 was not accompanied to his orthopedic appointment on 9/5/24 by the RP or a facility escort. The ADMIN and DON acknowledged the facility did not confirm and documented who was attending the appointment with Resident 1. A review of Resident 1's care plan, dated 8/30/24, indicated, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t physical limitations . A review of Resident 1's nursing progress note, dated 9/5/24 at 12:20 P.M., indicated, Transportation driver came back with packets and telling she cannot find resident in the building where resident went for appt . Social Service called the clinic that the driver cannot find resident in the building . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's nurses progress note, dated 9/5/24 at 1:35 P.M., indicated, Social service called . found that resident was sent to ER (emergency room) . A review of Resident 1 ' s interdisciplinary progress note, dated 9/5/24 at 2:20 P.M., indicated, .Resident family came into facility. Son and wife told SSD father [Resident 1] was taken to emergency room (ER) from Doctors appointment. After sitting outside in the sun, 911 was called. SSD called Doctor office that stated resident became combative after appointment and wheeled himself outside before transportation had arrived. Grievance process started . A review of the facility ' s policy, revised 1/22/24, titled Transportation, did not address how the facility provided escorts or accompanying residents to outside appointments. A review of the facility ' s policy, revised 12/9/22, titled Accidents and Supervision, indicated, Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents .