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	05/12/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one of three sampled residents (Resident 1) to return to the facility following a visit to the emergency department.This failure had the potential for Resident 1 to not receive continuity of care and violated his right to return to the facility per the facility's policy.Findings:According to the facility's admission Record, Resident 2 was admitted to the facility on [DATE] with diagnoses which included aphasia (a disorder which affects a person's ability to speak or understand speech) following cerebral infarction (a stroke).During a record review, the Minimum Data Set (MDS- a federally mandated assessment tool) dated 3/28/26 indicated Resident 2 had a Brief Interview for Mental Status (BIMS- a tool to assess thinking skills) of 12, which indicated moderate cognitive impairment.A review of the document titled Interdisciplinary Care Conference dated 3/31/26 indicated, Discharge plan.Patient is homeless, does [sic] not have a dc [discharge] plan.During an interview with the Administrator (ADMIN), on 4/29/26 at 9:35 A.M., the ADMIN stated on 4/14/26, Resident 2 was transferred to the hospital for evaluation related to unresolved headaches. The ADMIN stated a CT (computed tomography- a type of x-ray to create images of the body) scan was performed at the hospital. The ADMIN stated the CT scan was negative, and Resident 2 was not admitted to the hospital. The ADMIN further stated upon completion of the CT scan at the hospital, Resident 2 was not permitted to return to the facility because he was independent with ADL's, had altercations with other residents, and behaviors. Additionally, the facility had accommodated Resident 2 with a private room. The ADMIN stated, This is probably not the best place for him and the facility's admissions director was instructed to not to accept Resident 2 back to the facility.During a telephone interview with Resident 2 on 4/29/26 at 7:52 A.M., Resident 2 stated on 4/14/26, after he had completed the CT scan and was cleared to return to the facility, the hospital Case Manager informed him the facility would not allow him to return. Resident 2 stated, after the exam, I just sat there waiting to see if I would have a ride back to the facility. They told me, [the facility] doesn't want you back. Resident 2 stated since he was homeless, and could not return to the facility, he used a ride share service to drive him to a friend's office space. Resident 2 stated his personal belongings were still at the facility, and he did not have any medications with him, including Plavix, a medication to prevent blood clots.During a record review of the Emergency Department document titled Case Management Note, the document indicated, Cm [Case Management] spoke with [facility liaison].regarding pt's [patient's] return. Per [facility liaison] pt already hit one of his room mates, he is demanding private room which is not available at this time.An interview with the Social Services Director (SSD) was conducted on 4/29/26 at 10:02 A.M., The SSD stated Resident 2 was homeless, did not have any income, and did not have a specific discharge plan yet. The SSD stated when Resident 2 became ready to be discharged , she planned on assisting Resident 2 with applying for Social Security benefits. The SSD stated if or when Resident 2 was approved, she would have assisted Resident 2 with placement into either an Assisted Living Facility or an Independent Living Facility, depending on the amount of Social Security benefits. The SSD stated she would have coordinated with Home Health Agencies to provide services for Resident 2 after discharge. The SSD (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the plan was to assist Resident 2 with a safe discharge. During a telephone interview with Resident 2's primary care physician (PCP) 1 on 4/29/26 AT 10:50 A.M., PCP 1 stated Resident 2 was medically cleared to return to the facility after the Emergency Department visit on 4/14/29. PCP 1 stated, My presumption was that [Resident 2] was going to go back [to the facility].Why he couldn't return back, I don't know the answer. PCP 1 acknowledged Resident 2 did not have any orders for discharge from the facility as of 4/14/26.During a concurrent interview and record review with Licensed Nurse (LN) 1 on 4/29/26 at 11:45 A.M., LN 1 stated a safe discharge plan consisted of a physician's order, post-discharge education provided to the resident or their representative, and coordination with home health services. LN 1 acknowledged Resident 1 did not have documentation which indicated a physician's order for discharge and no education provided to Resident 1 regarding medications or discharge instructions. LN 1 further stated medications and their personal belongings would be provided to residents. LN 1 stated it was important to follow the facility's discharge process for continuity of care, and to ensure residents had a safe and coordinated discharge.During an interview with the Director of Nursing (DON) on 5/12/26 at 3:44 P.M., the DON stated her expectation was for a coordinated and planned discharge, to ensure residents' safety.During a review of the facility's policy titled Discharge Planning Process, revised 12/29/22, the policy 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 facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge.

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F 0689 Level of Harm - 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** Based on interview, and record review, the facility failed to provide care and services to prevent accidents for one of five sampled residents (Resident 1) who has left sided hemiplegia (paralysis affecting one side of the body) and hemiparesis (one-sided weakness). Resident 1 was left unattended in bed while she was turned on her left side and the bed raised in a high position.As a result, Resident 1 fell off the bed and sustained a femoral neck fracture (fractured hip), which required surgical intervention.Findings:During a record review, the undated Facility admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia (a form of paralysis that causes loss of movement to one side of the body) following cerebral infarction (a stroke) affecting left non-dominant side, generalized muscle weakness, lumbago with sciatica on the right side (pain which radiates from the lower back and travels down the left buttock, thigh, leg and feet), and need for assistance with personal care.During a review of the Minimum Data Set (MDS- a federally mandated assessment tool), dated 2/10/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to measure cognition, or mental processes) of 13 which indicated Resident 1 was cognitively intact. The MDS section GG further indicated Resident 1 was fully dependent on staff for mobility, including the ability to roll from lying on her back to left and right side, and return to lying on the bed. According to section J of the MDS, Resident 1 did not have a history of falls prior to admission.During a record review of the facility's document titled eINTERACT Change in Condition Evaluation by Licensed Nurse (LN) 1, dated 4/24/26 at 8 A.M., the document indicated, Writer was notified by cna [Certified Nursing Assistant] that pt rolled off bed [sic]. Upon arrival RN [Registered Nurse] there for assessment [sic]. Pt stated that she was trying to turn on bedroom light while waiting for cna and her right leg slipped off the bed which cause her to roll off bed. pt was then assisted by 4 people back into bed with hoyer lift [a mechanical lift used to transfer patients]. pt stated her left knee hurt 5/10 [a pain rating of five out of ten, with ten being the most painful].During an interview with Certified Nursing Assistant (CNA) 1 on 5/1/26 at 9:55 A.M., CNA 1 stated she was Resident 1's assigned CNA on 4/24/26. CNA 1 stated, on 4/24/26, while assisting Resident 1 with getting changed and dressed, Resident 1 asked if the medication nurse could place a lidocaine patch (a medication used to relieve pain) on her back before she got fully dressed. CNA 1 stated she left Resident 1 in bed and positioned the resident on her left side. CNA 1 stated she did not position Resident 1 on her back before leaving to find the medication nurse. CNA 1 further stated the bed was in a raised high position, and that she did not lower the bed prior to leaving Resident 1's room. CNA 1 stated, I told [Resident 1] I'll be back to get the nurse so she can give you the [lidocaine] patch. CNA 1 stated a few minutes after she left the room; Resident 1 had fallen from the bed. CNA 1 stated, I should have asked her to lay on her back and lowered the bed and at least waited for another nurse to watch her while I got the nurse. CNA 1 stated Resident 1 would not have rolled off the bed if she had been laying on her back. CNA 1 stated it was unsafe to leave Resident 1 in a side lying position, with the bed raised in a high position.During an interview with Restorative Nursing Assistant (RNA) 1 on 5/1/26 at 10:29 A.M., RNA 1 stated she was walking down the hallway and heard Resident 1's roommate called out for help. RNA 1 stated she entered Resident 1's bedroom and observed Resident 1 on the floor, in a sitting position, facing the bed. RNA 1 stated, Resident 1's right leg was bent and the left leg was on top of the right leg. RNA 1 further stated she observed Resident 1's bed was at a raised/waist level at the time of the fall.During a telephone interview with Resident 1 on 5/8/26 at 4:17 P.M., Resident 1 stated, [CNA 1] was going to change my brief, but first she went to ask for my lidocaine patch. Resident 1 stated she was lying on her left side, close to the edge of the bed, and I changed my weight distribution. I don't remember how, but my weight shifted, I didn't intentionally roll. Resident 1 stated, they could've left me on my (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	back when [CNA 1] left the room.they could have centered me in the bed so I couldn't roll off.During an interview with the Assistant Director of Nursing (ADON), on 5/12/26 at 9:30 A.M., the ADON stated she was responsible for investigating facility falls and led the Interdisciplinary Team Meeting (IDT- a group of individuals with different areas of expertise). The ADON stated Resident 1's fall was preventable if safety measures were provided prior to leaving Resident 1 without supervision. The ADON stated, a safe position would have been on her back, in the middle of the bed, and the bed was in a lower position.During an interview with the Director of Rehab (DOR) on 5/12/26 at 9:52 A.M., the DOR stated he was familiar with Resident 1 and had worked with her during her stay at the facility. The DOR stated Resident 1 was at risk for falls due to left side weakness, and having recently had surgery. The DOR stated he considered Resident 1's fall on 4/24/26 to be an avoidable fall. The DOR stated, I would have hit the resident's call light and waited for assistance , or get [Resident 1] in a supine position [lying flat on the back, facing upward] before leaving the room.A review of a hospital document titled Consultation Note dated 4/24/26 at 2:45 P.M., authored by Medical Doctor (MD) 1, indicated, The patient is a [AGE] year old who arrives by ambulance after falling out of bed. She states staff had rolled her onto her side.she excellently [sic] rolled off the bed.She was at her skilled nursing facility today when they went to go change her she was on her right side when she is not sure where the person went and then she fell rolled back off of the bed and onto her butt on the floor and had immediate pain in her hip. She was brought here and found to have a displaced femoral neck fracture [a broken hip].She was able to walk around Thanksgiving at rehab prior to her second surgery. The document further stated, Assessment/Plan.Discussed the severity of the injury with the patient and family. This is a particularly challenging injury in someone with her functional deficits.her options would be a hemi hip arthroplasty [joint replacement surgery] versus a [NAME] [a type of hip surgery done, without placing an artificial hip joint]. A [NAME] would [NAME] her of the ability to ambulate [walk]on this leg in the future but help with her significant pain. A hemi [hip arthroplasty] would carry significant risk of dislocation as well as periprosthetic fracture.but would give her the hope of potentially walking as accomplish goals of pain control. After a very long discussion with her and her husband they would like to proceed with a left hip hemiarthroplasty to hopefully allow for transfers or ambulation in the future.She understands if she dislocates she would likely require a [NAME] and this would not allow her to ambulate.Other risks [of surgical intervention] were reviewed including pain, bleeding, blood clots, anesthesia, medical complications, dislocation, periprosthetic fractures, loosening, infection requiring multiple procedures and unforeseen complications.During a review of the facility's policy titled Fall Prevention Program revised 4/20/26, the policy indicated, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.At risk protocols.Provide additional interventions as directed by the resident's assessment, including but not limited to.Assistive devices.increased frequency of rounds.low bed.