

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER The Shores Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Meadowlark Drive San Diego, CA 92123	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</p> <p>Based on interview and record review, the facility failed to ensure facility policy related to elopement (leaving; wandering off without notice) was implemented (followed) when one resident (1) eloped from the facility.</p> <p>As a result, a facility-wide emergency to locate Resident 1 was not initiated immediately upon finding out that Resident 1 was missing. This failure had the potential to affect Resident 1's health and safety.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of paranoid schizophrenia (brain disorder that affects the way a person thinks and behaves; characterized by suspicious feelings and difficulty distinguishing between what is real and what is not) per Resident 1's Admission Record.</p> <p>On 5/7/24, an unannounced visit was made to the facility in response to a facility reported incident that occurred on 5/5/24.</p> <p>A review of Resident 1's record was conducted. The Elopement Risk assessment dated [DATE], indicated Resident 1 scored seven (7) out of 29 possible points, indicating that Resident 1 was a moderate risk for elopement.</p> <p>A record review of Resident 1's Minimum Data Set (MDS; assessment tool) dated 4/11/24 indicated Resident 1 had a score of eight (8) out of 15 obtained on the Brief Interview for Mental status (BIMS; assessment tool; score of 8 indicated moderate cognitive impairment).</p> <p>On 5/8/24 at 8:51 A.M., an interview was conducted with the certified nursing assistant (CNA) 1. CNA 1 stated that on 5/5/24, at the beginning of her (work) shift, she only peeked inside Resident 1's room, and was only able to see Resident 1's roommate. CNA 1 stated that during the final (for the shift) rounds (checking in on residents) on 5/6/24 at approximately 5:30 A.M., she went inside Resident 1's room and noticed that Resident 1's bed was undisturbed and clean. CNA 1 stated she realized she had not seen Resident 1 throughout the shift and spoke with Resident 1's roommate. Resident 1's roommate stated that he did not see Resident 1 the whole night. CNA 1 stated that she immediately notified the charge nurse .</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER The Shores Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Meadowlark Drive San Diego, CA 92123	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/8/24 at 9:24 A.M., an interview was conducted with the licensed nurse/charge nurse (LN) 1. LN 1 stated he worked a 12 hour (9 P.M. to 9 A.M.) shift on 5/5/24, and knew Resident 1 was not in the facility since the beginning of his shift because he noticed Resident 1 was not walking around the facility like he usually did. LN 1 stated that on 5/5/24, he went inside Resident 1's room at 11 P.M. and did not see him inside. LN 1 stated that Resident 1's bed looked untouched and that he knew Resident 1 was not in the facility during the beginning of his rounds because Resident 1's roommate had told him that he did not see Resident 1 since 7 P.M. LN 1 stated he did not initiate the facility-wide emergency to call a Code [NAME] (missing person) or called the director of nursing (DON) at that time because he did not think Resident 1 was actually missing, and because it did not happen during his shift. LN 1 stated that the director of staff development (DSD) called a Code [NAME] on 5/6/24 at around 6 A.M., and that the DON called him around 7 A.M. or 8 A.M. and instructed him to notify the police.</p> <p>On 5/8/24 at 10:53 A.M., an interview was conducted with the DON. The DON stated that LN 1 did not notify and initiate a Code [NAME] at the beginning of NOC (night) shift (11 P.M. on 5/5/24) when he noticed Resident 1's bed was untouched. The DON stated that LN 1 should had initiated a Code [NAME] and helped to look for Resident 1 right away when LN 1 first noticed that Resident 1 was not in the facility. The DON further stated that her expectations was for the staff to conduct/complete their safety rounds and to not assume that residents were in their rooms, but to go inside the resident's rooms and check that they were there.</p> <p>According to the facility's elopement policy and procedures dated August 2014 titled Wandering, Unsafe Resident, indicated .4. A missing resident is considered a facility-wide emergency. If a resident is missing, the elopement/missing resident emergency procedure will be initiated. a) determine if the resident is out on an authorized leave or pass; c. If the resident was not authorized to leave, initiate a search of the building(s) and premises. c. If the resident is not located, notify the Administrator and the Director of Nursing Services .</p>		