

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 01/31/2025
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement an effective discharge planning process for one of three residents (Resident 1) reviewed for discharge. As a result, Resident 1 was re-hospitalized due to ineffective discharge planning and care-giver support related to care.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral infarction (also known as a stroke; disrupted blood flow to the brain) with left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it difficult to perform everyday activities such as eating or dressing) affecting the left side of the body. Resident 1 discharged home on 1/13/25.</p> <p>A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 12/2/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 1 did not have cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>On 1/30/25 at 1:05 P.M., an interview was conducted with the Social Service Director (SSD). The SSD stated that Resident 1 wanted to discharge home, and that she (the SSD) physically visited Resident 1's son in November 2024, to speak with him regarding Resident 1 's request to discharge home with him. The SSD stated that the son stated he was fine with Resident 1 returning home, but requested for Resident 1 to have a 24-hour caregiver since he was unable to provide the 24-hour care for his mom due to work and the level of care that she needed. The SSD stated Resident 1 did not qualify for 24-hour caregiver services, and that Resident 1 informed the SSD that Resident 1's former roommate at the facility would live with Resident 1 and be involved with Resident 1 's care in exchange for rent assistance at Resident 1 's son 's house.</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
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/30/25 at 1:18 P.M., an interview was conducted with Resident 1, in Resident 1 ' s room. Resident 1 stated the facility discharged her to her son ' s home without a care-giver present to assist her. Resident 1 stated the facility did not set me up with a care giver like they told me they would, and when I got home there was nobody to help me, and I need 24-hour care. Resident 1 stated [former roommate name] can ' t help me all on her own. She was not supposed to be my care giver. Resident 1 stated that her son was the one taking care of her but that she returned to the hospital because they (son and son ' s wife) couldn ' t take care of me properly, so I went back to the hospital the next day.</p> <p>On 1/30/25 at 1:43 P.M., a concurrent interview and record review was conducted with the SSD. The SSD stated that she was unable to verbally get confirmation from the son if he would be home on 1/13/25 for when Resident 1 discharged back to his home. The SSD reviewed Resident 1 ' s clinical chart and stated there was no documentation regarding her attempt to reach out to Resident 1 ' s son to confirm if he would be home during Resident 1 ' s discharge date d 1/13/25. The SSD stated Resident 1 required 24-hour care because Resident 1 was not fully independent with care needs, requiring maximal (helper does more than half the effort of lifting) to partial assistance (helper less than half the effort of lifting) with toileting due to incontinence (unable to control urine and feces), and required assistance for incontinent pad changes, transfers, bathing/showers, dressing, and set-up assistance with eating. The SSD stated Resident 1 was unable to walk and required a wheelchair. The SSD stated that prior to discharge, they did not set up any teaching or return demonstration with Resident 1 ' s son or former roommate to assure the safety of Resident 1. The SSD stated she relied on [Care Management Name] to provide the care giver assistance required for Resident 1 ' s care upon discharge. The SSD stated [Care Management Name] would not provide 24-hour care giver services for Resident 1.</p> <p>On 1/30/25 at 3 P.M., an interview was conducted with the Administrator (ADM). The ADM stated it was important for the SSD to ensure that a safe discharge plan was in place and documented to support Resident 1 ' s discharge plan home.</p> <p>On 1/30/25 at 5 P.M., a clinical chart review of Resident 1 ' s discharge care plan was conducted. The discharge care plan initiated 6/12/24, revised 6/12/24 indicated Resident has no plans for discharge. Unable to return home of record. Family unable to care for needs .</p> <p>On 1/31/24 10:06 A.M., a concurrent interview and record review was conducted with the Case Manager (CM) and the SSD. The CM stated that text messages were exchanged between [Care Management Name] for Resident 1 ' s discharge, but was unable to provide clinical documentation to support that Resident 1 would be receiving care giver assistance by [Care Management Name] on the 1/13/25 discharge date home. The SSD stated she was responsible for Resident 1 ' s discharge planning and stated she did not update Resident 1 ' s care plan timely. The SSD stated, it ' s important to update the care plan because it shows that the discharge planning was taking place. The SSD stated that Resident 1 ' s discharge plan did not reflect a safe discharge when [Company Management Name] was not available, because they were not providing 24 hour care-giving assistance. The SSD further stated it was important that the discharge care plan be updated and discussed with those involved with Resident 1 ' s discharge plans to ensure safety, care giver burden, and to prevent re-hospitalization s.</p> <p>(continued on next page)</p>		

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