STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555659	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	1201 South Orange Ave. El Cajon, CA 92020

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interviews and record reviews, the facility failed to develop a baseline care plan (detailed plan with information about a resident's treatment, goal, and interventions) for one of one sampled resident related to a resident's (Resident 1) multiple episodes of leaving the facility. As a result, the lack of a resident centered care plan with specific interventions had Resident 1 left the facility unnoticed by staff, got hit by a pickup truck and died on [DATE]. Findings: On [DATE], the Department received a facility reported incident (FRI) related to quality of care and resident safety. On [DATE], a follow up, unannounced onsite visit to the facility was conducted. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a condition where symptoms of both psychotic and mood disorders are present together during one episode), per the facility's Admission Record. On [DATE], [DATE] and [DATE], a review of Resident 1's clinical record was conducted. Resident 1's History and Physical (H & P), dated [DATE], indicated the attending physician (AP) documented Resident 1 was admitted to the facility for rehabilitation and he had the capacity to understand and make decisions. Resident 1's minimum data set (MDS - an assessment tool), completed [DATE], indicated Resident 1's brief interview for mental status (BIMS, ability to recall) score was ,d+[DATE] (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). On [DATE] at 3:22 P.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was alert, oriented and was ambulatory without assistive devices. CNA 1 stated Resident 1 goes in and out of the building. CNA 1 stated he, Assumed Resident 1 went out walking on early morning of [DATE]. (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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:39 P.M., an interview with CNA 2 was conducted. CNA 2 stated Resident 1 would regularly go out around 6 P.M. and came back around 9 -9:30 P.M. to sleep. CNA 2 stated Sometimes he stays out longer, we don't see him the next day. If I leave at 10:30 P.M., the time I will get to see him is when I come back the next day. I work 8 hours. On [DATE] at 2:07 P.M., a joint review of Resident 1's clinical record and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated she was familiar with Resident 1 going out on pass (OOP). LN 1 stated she did not create a care plan for Resident 1 leaving the facility. On [DATE] at 12:20 P.M., a telephone interview with LN 3 was conducted. LN 3 stated she knew Resident 1 in passing, would go OOP with the other LNs. LN 3 stated she had seen Resident 1 walked out and come back to the facility. LN 3 stated she did not write a care plan for Resident 1. On [DATE] at 3:21 P.M., a telephone interview with LN 4 was conducted. LN 4 stated he was familiar with Resident 1. Per LN 4, Resident 1 went in and out of the building any time of the day. LN 4 stated Resident 1 sometimes sneaked out. LN 4 stated he did not create a care plan related to Resident 1's leaving the facility. On [DATE] at 11:19 A.M., a telephone interview with the Social Services Director (SSD) was conducted. The SSD stated she was informed Resident 1 was not in the facility on [DATE] around ,d+[DATE]:30 A.M. The SSD stated a search was conducted but the staff did not find Resident 1 in and out of the building. The SSD stated she called the police department and a police officer called back to inform SSD that on [DATE] at around 10:47 P.M., Resident 1 was crossing the street, got hit by a pick up truck and died . On [DATE] at 3:30 P.M., a telephone interview with the Assistant Director of Nursing was conducted. The ADON stated there was no care plan developed for Resident 1's wandering behavior. The ADON stated the care plan should be individualized and resident centered which included the education about the risk of going out. Per the facility's policy titled, Care Plans, Comprehensive, Person-Centered, revised [DATE], A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs .1. A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT, group of healthcare professionals) with input from the resident .6. The comprehensive, person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible .7. When possible, interventions should address the underlying source(s) of the problem .

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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 - 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** 40610 Based on interviews and record reviews, the facility failed to implement their policies related to accidents and supervision, elopements (leave without notice) and signing residents out, when staff did not: 1. Identified one of one resident (Resident 1) who left the facility and implement a search procedure (code green) when Resident 1 was not found in the facility. The facility did not announce a code green until the following day, approximately 12 hours since Resident 1 was last seen in the facility. 2. Consistently obtain a physician's order for an out on pass (OOP - out on pass, leave of absence), assess, and document in his clinical record the time he went out on pass and consistently sign the OOP form. The lack of communication among staff that they did not set eyes on Resident 1 resulted in Resident 1 leaving the facility unnoticed by staff, was hit by a pickup truck, and died on the night of [DATE]. Findings: On [DATE], the Department received a facility reported incident (FRI) related to quality of care and resident safety. On [DATE], a follow up unannounced onsite to the facility was conducted. 1. On [DATE], [DATE], and [DATE], a review of Resident 1's clinical record was conducted. A record review was conducted of Resident 1. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a condition where symptoms of both psychotic (a mental disorder characterized by a disconnection in reality and mood disorders are present together during one episode), per the facility's Admission Record. A record review was conducted of Resident 1.Resident 1's History and Physical (H & P), dated [DATE], indicated the attending physician (AP) documented Resident 1 was admitted to the facility for rehabilitation and Resident 1 had the capacity to understand and make decisions. A record review was conducted of Resident 1. Resident 1's minimum data set (MDS - an assessment tool), completed [DATE], indicated Resident 1's brief interview for mental status (BIMS, ability to recall) score was , d+[DATE] (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). A record review of Resident 1's physician orders were conducted. Per Resident 1's physician order dated [DATE] at 11:27 A.M., Telephone order .may go oop (out on pass) for 4 hours, one time only for oop for 1 Day. (continued on next page)

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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 - Actual harm Residents Affected - Few	A record review was conducted of Resident 1's licensed progress notes. Per a licensed nurse (LN) progress note dated [DATE] at 6:45 P.M., LN 3 documented, Resident observed in facility at approximately 1830 (6:30 pm) at nurse's station talking with staff, in stable condition. A record review was conducted of Resident 1's progress notes. Per a LN progress note dated [DATE] at 12:52 A.M., LN 4 documented, When doing rounds noted resident is not in his room. per pm shift nurse. resident signed out himself. A record review was conducted of Resident 1.Per a change in condition (CIC) progress notes dated [DATE] at 8:57 A.M., LN 1 documented, Nursing observations. evaluation, and recommendations are: Unable to locate resident .code green initiated, res. was not present in facility . A record review was conducted of Resident 1's licensed nurse (LN) progress notes . Per a LN progress note dated [DATE] at 9:30 A.M., LN 1 documented, Certified Nursing Assistant (CNA) notified this nurse at approximately ,d+[DATE] this morning that res (Resident 1) is not in his room. Rounds made, res is not in his room or anywhere in the facility . A record review was conducted of Resident 1's physician order summary. Per Resident 1's order summary active as of [DATE], indicated there was no physician order for OOP. On [DATE] at 3:22 P.M., an interview with CNA 1 was conducted. CNA 1 stated he worked on [DATE] from 12 midnight (MN) to 6:30 A.M., and Resident 1 was assigned to him. CNA 1 stated Resident 1 was alert, oriented, and was ambulatory without assistive devices. CNA 1 stated he did not find Resident 1 in his bed. Per CNA 1, he looked for Resident 1 in the facility, did not find him and did not report to the licensed nurse (LN) 4 that Resident 1 was nowhere to be found. Per CNA 1, since LN 4 did not ask him to look for Resident 1, he kept his assumption that LN 4 knew Resident 1's whereabouts. CNA 1 stated the facility's policy was when the staff did not find a resident in his/her bed, staff need to inform the LNs, code green is called, and the staff will look for the resident in and out of the building. CNA 1 stated he completed his shift without knowledge of code green initiated. On [DATE] at 4:39 P.M., an interview with CNA 2 was conducted. CNA 2 stated on [DATE], Resident 1 was assigned to him. CNA 2 stated he last saw Resident 1 around 8 P.M. at the nurses' station talking with LN 2. CNA 2 stated he left around 10:30 P.M. and did not check if Resident 1 was in his bed because Resident 1's door was closed. CNA 2 stated Resident 1 would regularly go out of the facility around 6 P.M. and came back around 9 -9:30 P.M. to sleep. CNA 2 stated, Sometimes he stays out longer, we don't see him the next day. If I leave at 10:30 P.M., the time I will get to see him is when I come back the next day. I work 8 hours. CNA 2 stated from 8 -10:30 P.M., no code green was called. On [DATE] at 2:07 P.M., a joint review of Resident 1's clinical record and an interview with LN 1 was conducted. LN 1 stated she was familiar with Resident 1 going OOP. LN 1 stated the facility's process was when a resident went out on pass, LNs would have to assess the resident, obtain a physician's order, signed the resident in and out, document in the binder titled Leave of Absence (LOA - going out on pass to leave the facility) and document in the resident's progress notes. LN 1 stated on [DATE], she obtained an order from Resident 1's AP for OOP and knew Resident 1 left during her shift. LN 1 stated on [DATE] in the morning shift (7 A.M to 3 P.M.), Resident 1 was nowhere to be found and a code green was initiated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:48 A.M., a telephone interview with the AP was conducted. The AP stated she was not aware Resident 1 went OOP few times a day. The AP stated the LNs should have been getting a physician's order every time residents under her care went OOP. The AP stated each OOP was applicable with each event. The AP stated, They have to call me. The AP stated she knew Resident 1 went OOP on [DATE] and that he was back for dinner. The AP stated she did not know what happened until the following morning that Resident 1 was nowhere to be found. On [DATE] at 11:19 A.M., a telephone interview with the Social Services Director (SSD) was conducted. The SSD stated she was informed Resident 1 was not in the facility on [DATE] around ,d+[DATE]:30 A.M. The SSD stated a code green was called at this time and a search was conducted, but the staff did not find Resident 1 in and out of the building. The SSD stated she called the police department and a police officer called back to inform SSD that on [DATE] at around 10:47 P.M., Resident 1 was crossing the street, got hit by a pickup truck, and died . On [DATE] at 11:58 P.M., a telephone interview with LN 2 was conducted. LN 2 stated she was familiar with Resident 1. LN 2 stated Resident 1 was not assigned to her, but she talked to him on [DATE] around , d+[DATE] P.M. LN 2 stated Resident 1 was alert and oriented and walked independently. LN 2 stated the policy was for the residents to inform the LNs about going OOP, LNs obtained a physician's order, residents sign in and out the LOA binder, and a LN will have to sign them off. LN 2 stated with Resident 1's AP, the LNs were to get a physician's order when her residents requested to go OOP. LN 2 also stated during endorsement or change of shifts, the outgoing and the incoming LNs were to make rounds, give reports and check the residents' whereabouts. LN 2 stated on [DATE], she left the facility around 11:20 P.M., and on her way out, she noticed there was an accident and several police cars and officers in the street (a block away from the facility). On [DATE] at 12:20 P.M., a telephone interview with LN 3 was conducted. LN 3 stated she worked as a floater (move from one section of the facility to another, working in different areas). LN 3 stated she knew Resident 1 in passing and would go OOP accompanied by other LNs. LN 3 stated on [DATE], she worked at 3 P.M - 11 P.M. shift. LN 3 stated Resident 1 was assigned to her, and this was the second time she had him. LN 3 stated she did not consider Resident 1 an elopement risk. LN 3 stated she had seen Resident 1 walked out and come back to the facility. Per LN 3, on [DATE], she received a report from the morning LN that Resident 1 went OOP in the morning and that, He will come back. Per LN 3, around 6:30 P.M., she saw Resident 1 while she was passing medications (meds). Per LN 3, during the shift change (11 PM - 7 AM), the oncoming LN (LN 4) reported to her that Resident 1 was not in his bed. LN 3 stated, I wasn't worried, he knew that he was supposed to sign in. I was busy, I looked over and saw him there, he was back on my shift. Per LN 3, she and LN 4 did not make rounds together. LN 3 stated, I assumed most likely he was around .he does walk around and was not an elopement risk. LN 3 stated she and LN 4 did not verify the leave of absence (LOA) binder if Resident 1 had signed out. LN 3 stated Resident 1 had meds and she did not give it since she thought Resident 1 was not in his bed. LN 3 stated there was no door alarm that went off during her shift. LN 3 further stated, I assume he was asleep. To me, he was fine, he closed his room and I assume he was in his room, I should have not assumed, I learned that now. Should have I known that we should have looked around to find him. On [DATE] at 1:15 P.M., a telephone interview with security guard (SG) was conducted. SG stated on [DATE], he worked from 9 P.M. to 5 A.M. SG stated he last saw Resident 1 headed back to the building at around 9 P.M. Per SG, there was no code green that was called during his shift. (continued on next page)

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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 - Actual harm Residents Affected - Few	On [DATE] at 3:21 P.M., a telephone interview with LN 4 was conducted. LN 4 stated he was familiar with Resident 1. Per LN 4, Resident 1 went in and out of the building any time of the day and sometimes snuck out. Per LN 4, during the change of shift on [DATE], he noticed Resident 1 was not in his bed and asked LN 3. Per LN 4, LN 3 told him Resident 1 signed out. LN 4 stated he did not find the LOA binder to verify if Resident 1 went OOP. LN 4 stated he lost track. LN 4 stated should LN 3 had not mentioned Resident 1 was on OOP, We could have looked for him. LN 4 stated Resident 1 usually visited the area where he had the accident. LN 4 stated, I passed by that area. I saw him there before. 2. On [DATE] at 2:07 P.M., a joint review of Resident 1's clinical record and an interview with LN 1 was conducted. LN 1 stated Resident 1 regularly went OOP. Per LN 1, Resident 1's OOP form had incomplete documentation. LN 1 stated there were columns for residents and the LNs had to fill up which included the date, time out, scheduled return time, name of Responsible Party (RP), signature of RP, nurse initial, RP contact number, time returned, Signature of RP when returned and another column for the nurse initial. LN 1 stated and verified that Resident 1 went OOP on the following dates: - [DATE], Resident 1 left at 12:37 P.M., came back at 4:45 P.M. LN 1 stated the OOP form was incomplete missing the signature of RP when returned. - [DATE], LN 1 stated Resident 1 left again at 7 P.M. LN 1 stated there was no physician's order, and the OOP form was incomplete missing LN signature for the 7 P.M. OOP, RP signature when returned, time returned, and LN signature when Resident 1 came back after the 7 P.M. OOP. - [DATE], LN 1 stated Resident 1 left at 2:25 P.M., came back at 3:30 P.M. LN 1 stated there was no physician's order, and the OOP form was missing the RP signature when returned and LN signature when Resident 1 came back. - [DATE], LN 1 stated Resident 1 left at 11:26 A.M. LN 1 stated the OOP form was missing the scheduled return time, the nurse initial, the RP contact number, the signature of RP when returned and LN signature when Resident 1 came back. - [DATE], LN 1 stated Resident 1 left 4:58 P.M. LN 1 stated there was no physician's order for the 4:58 P.M. OOP and the OOP form was missing the scheduled return time, the RP contact number, the time returned, the signature of RP when returned and LN signature when Resident 1 came back. - [DATE], LN 1 stated there was no physician's order and the OOP form was missing the time out, the scheduled return time, RP signature when returned, time returned and the LNs signature when Resident 1 went out and came back to the facility. - [DATE], LN 1 stated Resident 1's OOP form had two entries. LN 1 stated the OOP form was missing the time out, the scheduled return time, the nurse initial, and the RP signature when returned. LN 1 stated she was the one who signed the resident back at 4 P.M. - [DATE], LN 1 stated Resident 1 left again at 5:26 P.M. LN 1 stated the OOP form was incomplete and missing the scheduled return time, the nurse initial, and the RP signature when returned. LN 1 stated she mistakenly signed the column for nurse initial. LN 1 stated there were no physician's order on both events. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE], LN 1 stated the OOP form was incomplete and missing the time out, the scheduled return time, the nurse initial, and the RP signature when returned. LN 1 stated she was the one who signed the resident back but did not indicate the time. - [DATE], LN 1 stated the OOP form was incomplete and missing the time out, the scheduled return time, the nurse initial, and the RP signature when returned. LN 1 stated she was not sure whose signature was in the form if it was the RP or the LN. - [DATE], LN 1 stated Resident 1 left at 11:46 A.M., and was expected to return 3:45 P.M. LN 1 stated the OOP form was incomplete and missing the signature of RP, the RP contact number, the time returned and the RP signature when returned. LN 1 stated the policy was to fill up the OOP form completely so that the staff knew where the residents were. LN 1 stated aside from obtaining a physician's order and filling out the OOP form, the LNs must document in the residents' clinical record when they leave the facility and when they come back. LN 1 stated the staff should be aware when residents leave OOP and their condition before and after their OOP. The following dates had missing LN progress documentation: [DATE], [DATE], [DATE], [DATE] at 5:26 P.M. event, [DATE], and on [DATE], no documentation when Resident 1 came back to the building. On [DATE] at 12:58 P.M., a telephone interview with LN 5 was conducted. LN 5 stated Resident 1 was admitted on [DATE] and there was no OOP order for the resident. Per LN 5, the LNs should be obtaining an order from the attending physician every time Resident 1 goes OOP. On [DATE] at 3:30 P.M., a telephone interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated the expectation was when the staff did not see the resident in their room or in their bed, the staff should initiate a code green, start searching for the resident, and notify the attending physician, the RP and the management. The ADON stated if unable to locate the resident, the staff should call the police. The ADON stated the staff should have made rounds to ensure Resident 1 was in his bed for resident safety. The ADON also stated the expectation was to complete the OOP form and document that the residents were acknowledging that they were going out of the building and staff knew they were out. This was to inform the residents that the facility was not liable when they went out of the building and that knew the risks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of the facility's policy was conducted. Per the facility's policy titled Safety and Supervision of Residents, revised [DATE], .Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Individualized, Resident-Centered Approach to Safety. 1. Our individualized, resident-centered approach to safety addresses safety .for individual residents, 2. The interdisciplinary care team shall analyze information obtained from .observations to identify any specific accident hazards or risks for individual residents .3. The care team shall target interventions to reduce individual risks related to hazards .including adequate supervision .4. Implementing interventions to reduce accident risks .shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions .d. Ensuring that interventions are implemented; and e. Documenting interventions .Systems Approach to Safety, 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified . and individual resident risk factors, and then adjusts interventions accordingly, 2. Resident supervision is a core component of the systems approach to safety .Resident Risks and Environmental Hazards, 1. Due to their complexity and scope, certain resident risk factors .are addressed in dedicated policies and procedures. These risk factors .include .5. Unsafe Wandering . A record review of the facility's policy was conducted. Per the facility's policy titled Elopements, revised [DATE], Staff shall investigate and report all cases of missing residents . Policy Interpretation and Implementation, 1. Staff shall promptly report any resident who .is suspected of being missing to the Charge Nurse or Director of Nursing .4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on an authorized leave of pass; b. 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, the resident's legal representative .the Attending Physician, law enforcement officials .d. Provide search teams .e. Initiate an extensive search of the surrounding area . A record review of the facility's policy was conducted. Per the facility's policy titled Signing Residents Out, revised [DATE], All residents leaving the premises must be signed out .1. Each resident leaving the premises (excluding transfers/ discharges) must be signed out. 2. A sign-out register is located at each nurses' station. Registers must indicate the resident's expected time of return .