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	01/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review the facility failed to ensure complete and accurate medical records were documented for two of seven residents (Resident 3 and 7) reviewed for resident records when: 1. Resident 3 and 7's inventory of personal items were not signed by the resident or the resident representative upon transfer to the hospital, 2. There was no documentation regarding following up with Resident 7's responsible party when the resident expired, 3. There was no physician's order to release Resident 7's body to the mortuary. This failure had the potential to result in inaccurate account of residents' belongings. In addition, the RP and md was not aware that Resident 7 expired and there was no physician's order to release Resident 7's body to the mortuary. Findings: 1a. Resident 3 was readmitted to the facility on [DATE] with diagnoses including congestive heart (a condition in which the heart does not pump blood as well as it should) failure and muscle weakness according to the facility's Admission Record. During a review of Resident 3's Minimum Data Set (MDS-a clinical assessment tool) dated [DATE], the MDS indicated a brief interview of mental status (BIMS) score of 14, indicating Resident 3 was cognitively intact. An interview was conducted with Resident 3 on [DATE] at 10:51 A.M. Resident 3 stated he had been in and out of the hospital and the facility. Resident 3 stated his cell phone, $730, gold necklace and green card has been missing. Resident stated he was at the hospital, and they [facility] took everything from him. (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's medical record titled, Inventory of Personal Items was conducted. The inventory form dated [DATE] indicated two pants, two shirts, cell phone with charger, shaver, glasses, and a wallet with identification cards. The Upon Discharge section of the form dated [DATE] did not have signatures from Resident 3 and facility staff. There was no documentation to indicate Resident 3's belongings remained in the facility or given to Resident 3. The inventory form dated [DATE] indicated 2 pants, 1 shirt and socks. The inventory form dated [DATE] indicated two hoodies, six pants, six shirts, a beanie, one belt, a cell phone and phone charger. The On Discharge section of the inventory forms for [DATE] and [DATE] did not have signatures from Resident 3 and facility staff. There was no documentation to indicate if Resident 3's belongings remained in the facility or given to Resident 3. The inventory form dated [DATE] (Resident 3's most current admission) indicated one pants and one shirt only. 1b. Resident 7 was readmitted to the facility on [DATE] with the diagnoses including hypertensive urgency (a severe elevation in blood pressure without evidence of damage to vital organs) according to the facility's Admission Record. During a review of nurse's note for Resident 7 dated [DATE], the nurse's note indicated a code blue (a life-threatening medical emergency) was called for Resident 7 and Resident 7 expired. A review of Resident 7's Inventory of Personal Items was conducted. The inventory indicated multiple clothing for Resident 7. The On Discharge section of the form did not have signatures from the resident's representative and staff. There was no documentation to indicate if Resident 7's belongings remained in the facility or given to Resident 7's responsible party. During an interview on [DATE] at 11:22 A.M. with Certified Nurse Assistant (CNA) 3, CNA 3 stated upon a resident's admission, an inventory of resident's personal belongings was taken and updated as needed. CNA 3 stated if an item was missing, staff would check laundry, notify the charge nurse and social services. An interview was conducted with licensed nurse (LN) 1 on [DATE] at 11:32 A.M. LN 1 stated CNAs were responsible for the inventory and labeling of residents' personal items. LN 1 stated if a resident was transferred to the hospital, the CNA or the LN will check what belongings were left in the room against the resident's inventory list. LN 1 stated if anything was missing, social services would be notified. LN 1 stated he was not sure if the inventory list was signed by the resident or responsible party upon resident's transfer to the hospital. An interview was conducted with LN 2 on [DATE] at 9:54 A.M. LN 2 stated an inventory sheet was completed by the admission nurse or a LN upon resident's admission to the facility. LN 2 stated if the resident was sent out to the emergency room (ER), the resident's belongings were packed by social services and kept in storage. LN 2 stated belongings taken by the resident to ER will be documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Service Assistant (SSA) on [DATE] at 10:36 A.M. The SSA stated the inventory sheet was completed by nursing staff and social services notified the resident's family to log any new items on the inventory sheet. The SSA stated if a resident was transferred to ER, the nursing staff packed the resident's belongings and brought them to the social service's office. The SSA stated resident's belongings were dated and logged when brought to the storage, as well as when the belongings were removed from the storage. The SSA stated inventory sheet was only signed if a resident had a planned discharge, not when a resident was transferred to ER. The SSA stated nursing staff would edit the inventory form if anything was taken out. An interview with the Assistant Director of Nursing (ADON) 1 was conducted on [DATE]. ADON 1 stated it was important to keep track of resident belongings to ensure that nothing was missing. A review of the facility's policy and procedure (P&P) titled, Discharging the Resident, dated [DATE] was conducted. The P&P indicated, .Review the personal effects inventory with the resident or responsible party and have them sign off that they have received all personal effects . A review of the facility's policy and procedure (P&P) titled, Personal Property, dated [DATE] was conducted. The P&P indicated, .The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary . 2. Progress notes (PN) for Resident 7 were reviewed. The PN dated [DATE] at 12:59 P.M. indicated a code blue (a life-threatening medical emergency) was called for Resident 7 and Resident 7 expired. The PN indicated the emergency contact was called, but there was no answer. The following PN dated [DATE] at 3:40 P.M. indicated Resident 7 was transferred to the mortuary via gurney. There was no documentation in Resident 7's medical record as other attempts to contact Resident 7's responsible party. The PN dated [DATE] at 3:52 P.M. indicated Resident 7's significant other asked information regarding Resident 7 whom she had not spoken to for one to two weeks and has been very worried. The PN indicated the LN did not have any information and will have the supervisor reach out to the significant other. An interview with the Assistant Director of Nursing (ADON) was conducted on [DATE] at 11:39 A.M. The ADON reviewed the progress notes for Resident 7. The ADON stated Resident 7 had a wife as the emergency contact. The ADON stated the nursing staff and social services had attempted to contact Resident 7's wife but was unsuccessful in reaching her. The ADON stated Resident 7's progress notes did not have documentation that staff attempted to reach Resident 7's wife. The ADON stated it was important for Resident 7's wife to know what had happened to Resident 7. A review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated February 2021 was conducted. The P&P indicated, .Unless otherwise instructed by the resident, a nurse will notify the resident's representative when .there is a significant change in the resident's physical, mental, or psychological status . a decision has been made to discharge the resident from the facility . 3. Progress notes (PN) for Resident 7 were reviewed. The PN dated [DATE] at 12:59 P.M. indicated a code blue (a life-threatening medical emergency) was called for Resident 7 and Resident 7 expired. The PN dated [DATE] at 3:40 P.M. indicated Resident 7 was transferred to the mortuary via gurney. There was no documentation that the physician was notified, and an order was obtained to release Resident 7 to the mortuary. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Nurse (LN) 2 on [DATE] at 9:54 A.M. LN 2 stated a physician's order was needed for residents to be discharged from the facility which included releasing a resident to a mortuary. During an interview with LN 4 on [DATE] at 10:05 A.M., LN 4 stated the resident's attending physician must be notified if a resident expired in the facility. A concurrent record review and interview was conducted with the Assistant Director of Nursing (ADON) on [DATE] at 12:19 P.M. The ADON reviewed the physician's orders for Resident 7. The ADON stated there was no physician's order to release Resident 7's remains to the mortuary. The ADON stated there should be a physician's order for the physician to know where Resident 7 would be discharged to. During a review of the facility's policy and procedure (P&P) titled Physician Orders dated [DATE], the P&P indicated, Physician orders must be given, managed and carried out in accordance with applicable laws and regulations . The P&P did not address obtaining physician's orders to release resident's remains to the mortuary.