STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire San Dimas Post-Acute	1740 S San Dimas Ave San Dimas, CA 91773

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 36288 Based on interview and record review, the facility failed to ensure timely discharge planning was implemented for one of three sampled residents (Resident 2) by failing to: 1. Consider Resident 2's caregiver (Resident 2's Representative [R2R]) capacity and capability to perform the required discharge care for Resident 2 and provide R2R with caregiver training prior to discharge of Resident 2. 2. Assess Resident 2 for the need of assistive device/s at home to safely perform activities of daily living (ADLs) and for mobility. 3. Arrange and confirm home health services (medical services provided at a person's home to treat a chronic health condition or help with recovery from illness, injury, or surgery) as ordered by Resident 2's physician before Resident 2 was discharged from the facility. These failures had the potential for increased risk of complications and adverse events during the resident's transition to a new setting. Cross Reference F661 Findings: During a review of Resident 2's Admission Record (AR 2), the AR 2 indicated, the facility initially admitted Resident 2 on 5/20/2024, with multiple diagnoses including cerebral infarction (ischemic stroke- disrupted blood supply to the brain, causing tissue death) with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side, aphasia (language disorder affecting person's ability to understand and speak language), gait (manner of walking) and mobility abnormalities, muscle wasting (thinning of muscle mass) and atrophy (loss of muscle mass and strength), and need for assistance with personal care. During a review of Resident 2's History and Physical Examination (H&P 2), dated 5/20/2024, the H&P 2 indicated, Resident 2 was able to make needs known but could not make medical decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS 2- a standardized resident assessment and care-planning tool), dated 5/27/2024, the MDS 2 indicated, Resident 2 had absence of spoken words, had difficulty communicating some words or finishing thoughts but was able to if prompted or given time, and would miss part/intent of the message but would comprehend most of the conversation. The MDS 2 indicated, Resident 2 had some difficulty making decisions regarding tasks of daily life in new situations only. The MDS 2 indicated, Resident 2 was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. The MDS 2 indicated, Resident 2 required substantial/maximal assistance with oral hygiene, upper body dressing, personal hygiene, and mobility. During a review of Resident 2's Discharge Summary (DS 2), dated 7/9/, timed at 2:32 PM, the DS 2 indicated, Resident 2 was admitted to the facility for skilled physical therapy (PT- rehabilitative services aimed to relieve pain, improve movement, and strengthen weakened muscles) and occupational therapy (OT- rehabilitative services aimed to promote health and well-being through the performance of activities of daily living [ADLs]). The DS 2 indicated, Resident 2 was non-ambulatory (propels with device) and required assistance with ADLs, hygiene, & grooming. The DS 2 indicated, under Medical Equipment Ordered, Resident 2 did not have equipment needs. The DS 2 indicated, under Community Resources, the facility had arranged home health services with Home Health Agency (HHA- a public agency or private organization engaged in providing medical services provided at home) 1 including nursing, PT, and OT. The DS 2 indicated, no outpatient therapy services were arranged. During a review of Resident 2's Physician Order (MDO 1), dated 7/9/2024, timed at 6:29 PM, the MDO 1 indicated, an order to discharge Resident 2 to home with Home Health (unspecified) on 7/9/2024. The MDO 1 indicated, Resident 2 may have home health PT/OT & registered nurse (RN) for safety evaluation to follow. The MDO 1 indicated, Resident discharged home with family at 5:40 PM. During a telephone interview on 7/17/2024 at 2 PM with Resident 2's Representative (R2R), R2R stated Resident 2's discharge came as a total surprise. R2R stated R2R did not think Resident 2 was ready for discharge from the facility. R2R stated Resident 2's health insurance company called the facility on 7/9/2024 (date of discharge) at 2:20 PM to inform Resident 2 and R2R that health services and skilled nursing facility (SNF) stay would no longer be covered by Resident 2's health insurance. R2R stated R2R then picked up Resident 2 from the facility to avoid paying $350 per day out-of-pocket. R2R stated R2R did not appeal, because the facility informed R2R that per Resident 2's health insurance, the appeal could take up to 30 days. R2R stated she had no help at home. R2R stated R2R did not know how to lift or transfer Resident 2 from the bed. R2R stated there were no bed rails or any assistive device at home, and Resident 2's wheelchair was so heavy. R2R stated she could not shower Resident 2 and could only change Resident 2's diaper while Resident 2 was bed. R2R stated no home health Registered Nurse (RN), OT, PT visits were arranged. R2R stated R2R had her own medical issues and could not assist with Resident 2's mobility. During a concurrent interview and record review on 7/17/2024 at 2:50 PM with the Director of Nursing (DON), Resident 2's MDO 1 was reviewed. The DON stated the facility did not arrange the home health services prior to Resident 2's discharge from the facility. The DON stated the facility must follow the discharge order and maintain continuity of care to ensure Resident 2's safe discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and on 7/18/2024 at 8:42 AM with the Social Services Director (SSD), the SSD stated the facility must ensure a safe discharge of a resident (in general) by ensuring the resident had the necessary equipment at home, the facility made the follow-up appointments or instructed the family to make the follow-up appointments, and the facility arranged and confirmed (HHA have accepted the resident) the home health services to be provided The SSD stated the SSD informed R2R that Resident 2's last covered date at the facility by the health insurance company was 7/7/2024. The SSD stated on 7/8/2024, she submitted Resident 2's nursing notes, rehabilitation notes, and physician's notes to Resident 2's HIC for review to request for an extension of covered stay at the SNF. The SSD stated on 7/9/2024, Resident 2's HIC notified the facility that Resident 2's last covered date at the SNF was 7/8/2024, so Resident 2 had to be discharged by 7/9/2024 to avoid any out-of-pocket costs from Resident 2. The SSD stated because of the short notice, the SSD documented on Resident 2's Discharge Summary that HHA 1 was arranged without any confirmation from HHA 1. The SSD stated there had been no home health arrangements made and no updates from Resident 2's health insurance company's case manager regarding outpatient rehabilitation resources. During an interview on 7/18/2024 at 9:41 AM with the Rehabilitation Director (Rehab D), the Rehab D stated the Rehab D was very upset how it went down. The Rehab D stated the facility was not ready to discharge Resident 2 when Resident 2's HIC called the facility on 7/9/2024. The Rehab D stated on 7/14/2024 (5 days after Resident 2's discharge from the facility), the Rehab D personally came to Resident 2's home to make things right and check on Resident 2, since no home health services were arranged. The Rehab D stated the Rehab D assessed the layout of Resident 2's home for ADLs and mobility and determined it was not possible for R2R to assist Resident 2 with transfers to and from chair and ambulation due to R2R's difficulty with bending. The Rehab D stated Resident 2's shower chair did not fit in Resident 2's shower area. The Rehab D stated Resident 2 needed a Hemi-walker (device that gives support to maintain balance while walking and allows the user to lean on just one side for support), which was steadier when walking and safer assistive device than a cane. The Rehab D stated when home health services were not arranged as ordered, Resident 2 had a potential to decline and was at an increased risk for deconditioning (decline in physical function of the body because of physical inactivity and disuse). During an interview on 7/18/2024 at 12:30 PM with Registered Nurse (RN) 1, RN 1 stated RN 1 discharged Resident 2 on 7/9/2024. RN 1 stated RN 1 did not assess Resident 2's caregiver/support availability at home, equipment needed at home, or verified home health arrangements before and during discharge, because RN 1 assumed the SSD or case manager spoke to Resident 2 or R2R about these concerns. During an interview on 7/18/2024 at 2:42 PM with the Director of Nursing (DON), the DON stated discharge planning must begin on the first day of a resident's (in general) admission to the facility. The DON stated on 7/9/2024 (discharge date), R2R came to the facility and verbalized that Resident 2 was not ready for discharge to home. The DON stated the facility needed to question the rushed discharge date from Resident 2's health insurance company due to the need for more caregiver training and assistive device at home. The DON stated the facility needed to send out referrals to home health agencies timely and confirm home health services with visits from an RN, OT, and PT prior to discharging Resident 2 from the facility. The DON stated improper discharge planning could lead to an unsafe discharge, Resident 2's injury at home, and Resident 2's possible decline physically and mentally. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Social Services, dated 10/2010, the P&P indicated, the facility provided medically related social services to assure that each resident attained or maintained his/her highest practicable physical, mental, or psychosocial well-being. The P&P indicated, the social services department was responsible for making and maintaining appropriate documentation of referrals to agencies as necessary or appropriate, working with individuals or groups in developing supportive services for residents according to their individual needs and interests, and participating in the planning of the resident's return to home and community by assessing the impact of these changes and making arrangements for social and emotional support. During a review of the facility's P&P titled, Discharge Summary and Plan, dated 12/2016, the P&P indicated, when a resident's discharge was anticipated, a discharge summary and post-discharge plan was developed to assist the resident to adjust to his/her new living environment. The P&P indicated, as part of the discharge summary, every resident was evaluated for his or her discharge needs and had an individualized post-discharge plan. The P&P indicated, the facility developed the post-discharge plan and the post-discharge plan included arrangements that had been made for follow-up care and services and the degree of caregiver/support person availability, capacity, and capability to perform required care. The P&P indicated, the facility reviewed the final post-discharge plan with the resident and family at least 24 hours before the discharge was to take place.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 36288 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) had an accurate discharge summary by failing to accurately assess and document Resident 2's discharge care needs and post-discharge plan to ensure Resident 2's safe and effective transition to Resident 2's home. These failures resulted in the lack of continuity of care and a delay in the provision of care and services for Resident 2. Cross Reference F660 Findings: During a review of Resident 2's Admission Record (AR 2), the AR 2 indicated, the facility initially admitted Resident 2 on 5/20/2024, with multiple diagnoses including cerebral infarction (ischemic stroke- disrupted blood supply to the brain, causing tissue death) with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side, aphasia (language disorder affecting person's ability to understand and speak language), gait (manner of walking) and mobility abnormalities, muscle wasting (thinning of muscle mass) and atrophy (loss of muscle mass and strength), and need for assistance with personal care. During a review of Resident 2's History and Physical Examination (H&P 2), dated 5/20/2024, the H&P 2 indicated, Resident 2 was able to make needs known but could not make medical decisions. During a review of Resident 2's Minimum Data Set (MDS 2- a standardized resident assessment and care-planning tool), dated 5/27/2024, the MDS 2 indicated, Resident 2 had absence of spoken words, had difficulty communicating some words or finishing thoughts but was able to if prompted or given time, and would miss part/intent of the message but would comprehend most of the conversation. The MDS 2 indicated, Resident 2 had some difficulty making decisions regarding tasks of daily life in new situations only. The MDS 2 indicated, Resident 2 was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. The MDS 2 indicated, Resident 2 required substantial/maximal assistance with oral hygiene, upper body dressing, personal hygiene, and mobility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Discharge Summary (DS 2), dated 7/9/, timed at 2:32 PM, the DS 2 indicated, Resident 2 was admitted to the facility for skilled physical therapy (PT- rehabilitative services aimed to relieve pain, improve movement, and strengthen weakened muscles) and occupational therapy (OT- rehabilitative services aimed to promote health and well-being through the performance of activities of daily living [ADLs]). The DS 2 indicated, Resident 2 was non-ambulatory (propels with device) and required assistance with ADLs, hygiene, & grooming. The DS 2 indicated, under Medical Equipment Ordered, Resident 2 did not have equipment needs. The DS 2 indicated, under Community Resources, the facility had arranged home health services with Home Health Agency (HHA- a public agency or private organization engaged in providing medical services provided at home) 1 including nursing, PT, and OT. The DS 2 indicated, no outpatient therapy services were arranged. The DS 2 indicated, under Post-Discharge Appointments/Follow Up Visits, the family was to arrange follow-up appointment with Primary Care Physician 1 (PCP 1) if PCP 1 could accept a new patient. During a review of Resident 2's Notice of Proposed Transfer/Discharge (NPTD 2), dated 7/9/2024, timed at 2:47 PM, the NPTD 2 indicated, on 7/9/2024, the facility notified Resident 2/Resident 2's Representative (R2R) of Resident 2's discharge to home on the same day, 7/9/2024. The NPTD 2 indicated, the reason for discharge was due to Resident 2's transfer/discharge was appropriate because Resident 2's health had improved sufficiently so that the services of the facility were no longer required. The NPTD 2 indicated, R2R signed the NPTD 2 and wrote Acknowledgment of receipt - disagree with insurance reason. During a review of Resident 2's Physician Order (MDO 1), dated 7/9/2024, timed at 6:29 PM, the MDO 1 indicated, an order to discharge Resident 2 to home with Home Health (unspecified) on 7/9/2024. The MDO 1 indicated, Resident 2 may have home health PT/OT & registered nurse (RN) for safety evaluation to follow. The MDO 1 indicated, Resident discharged home with family at 5:40 PM. During a telephone interview on 7/17/2024 at 2 PM with R2R, R2R stated Resident 2's discharge came as a total surprise. R2R stated R2R did not think Resident 2 was ready for discharge from the facility. R2R stated Resident 2's health insurance company called the facility on 7/9/2024 (date of discharge) at 2:20 PM to inform Resident 2 and R2R that health services and skilled nursing facility (SNF) stay would no longer be covered by Resident 2's health insurance. R2R stated R2R then picked up Resident 2 from the facility to avoid paying $350 per day out-of-pocket. R2R stated R2R did not appeal, because the facility informed R2R that per Resident 2's health insurance, the appeal could take up to 30 days. R2R stated she had no help at home. R2R stated R2R did not know how to lift or transfer Resident 2 from the bed. R2R stated there were no bed rails or any assistive device at home, and Resident 2's wheelchair was so heavy. R2R stated she could not shower Resident 2 and could only change Resident 2's diaper while Resident 2 was bed. R2R stated no home health Registered Nurse (RN), OT, PT visits were arranged. R2R stated R2R had her own medical issues and could not assist with Resident 2's mobility. R2R stated R2R had a problem obtaining Resident 2's medications initially, but R2R was able to fix the issue after she settled the new primary care provider issue. During a concurrent interview and record review on 7/17/2024 at 2:50 PM with the Director of Nursing (DON), Resident 2's MDO 1 was reviewed. The DON stated the facility did not arrange the home health services prior to Resident 2's discharge from the facility. The DON stated the facility must follow the discharge order and maintain continuity of care to ensure Resident 2's safe discharge. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/2024 at 8:42 AM with the SSD, Resident 2's medical record was reviewed including a list of home health agency referrals for Resident 2. The SSD stated the SSD did not have any documented evidence of all referrals the SSD sent to the HHAs, since the SSD only made phone calls to the HHAs. The SSD stated the SSD did not document the HHA referrals or the phone calls she made in Resident 2's electronic health records. The SSD stated the SSD must ensure a safe discharge of a resident (in general) by ensuring the resident had the necessary equipment at home, the facility made the follow-up appointments or instructed the family to make the follow-up appointments, and the facility arranged and confirmed (HHA have accepted the resident) the home health services to be provided. The SSD stated the SSD informed R2R that Resident 2's last covered date by the health insurance company (HIC) in the facility was 7/7/2024. The SSD stated on 7/8/2024, she submitted Resident 2's nursing notes, rehabilitation notes, and physician's notes to Resident 2's HIC for review to request for an extension of covered stay at the SNF. The SSD stated on 7/9/2024, Resident 2's HIC notified the facility that Resident 2's last covered date at the SNF was 7/8/2024, so Resident 2 had to be discharged by 7/9/2024 to avoid any out-of-pocket costs. The SSD stated because of the short notice, the SSD documented on the DS 2 that home health services were arranged, because the facility worked with HHA 1. The SSD stated on 7/9/2024, after Resident 2 left the facility with R2R, the SSD called the HHAs provided by Resident 2's HIC and all the HHAs denied home health services for Resident 2. The SSD stated the SSD called Resident 2's HIC's case manager (CM 1), who stated she (CM 1) would send the SSD outpatient rehabilitation resources for Resident 2. The SSD stated since 7/9/2024 to present, there had been no updates from CM 1. During an interview on 7/18/2024 at 9:41 AM with the Rehabilitation Director (Rehab D), the Rehab D stated the Rehab D was very upset how it went down. The Rehab D stated the facility was not ready to discharge Resident 2 when Resident 2's HIC called the facility on 7/9/2024. The Rehab D stated on 7/14/2024 (5 days after Resident 2's discharge from the facility), the Rehab D personally came to Resident 2's home to make things right and check on Resident 2, since no home health services were arranged. The Rehab D stated the Rehab D assessed the layout of Resident 2's home for ADLs and mobility and determined it was not possible for R2R to assist Resident 2 with transfers to and from chair and ambulation due to R2R's difficulty with bending. The Rehab D stated Resident 2's shower chair did not fit in Resident 2's shower area. The Rehab D stated Resident 2 needed a Hemi-walker (device that gives support to maintain balance while walking and allows the user to lean on just one side for support), which was steadier when walking and safer assistive device than a cane. The Rehab D stated when home health services were not arranged as ordered, Resident 2 had a potential to decline and was at an increased risk for deconditioning (decline in physical function of the body because of physical inactivity and disuse). During a telephone interview on 7/18/2024 at 11:52 AM with the HHA 1's DON (HHA DON), the HHA DON stated HHA 1 did not receive a referral for Resident 2 from the facility. During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, dated 12/2016, the P&P indicated, when a resident's discharge was anticipated, a discharge summary and post-discharge plan was developed to assist the resident to adjust to his/her new living environment. The P&P indicated, as part of the discharge summary, every resident was evaluated for his or her discharge needs and had an individualized post-discharge plan. The P&P indicated, the facility developed the post-discharge plan and the post-discharge plan included arrangements that had been made for follow-up care and services and the degree of caregiver/support person availability, capacity, and capability to perform required care. The P&P indicated, the facility reviewed the final post-discharge plan with the resident and family at least 24 hours before the discharge was to take place.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on interview and record review, the facility failed to provide sufficient and appropriate social services to meet the needs of one of three sampled residents (Resident 1) by failing to: 1.Ensure the Social Services Director (SSD) documented evidence of timely referrals to long-term care (LTC- health-related care and services [above the level of room and board] not available in the community, needed regularly due to a mental of physical condition) facilities certified under Medicaid (a joint federal and state program that helps cover medical costs for people with limited income and resources) for Resident 1. 2. Ensure the SSD updated and individualized Resident 1's discharge care plan. These failures had the potential to cause a physical and psychosocial impact to Resident 1's well-being due to unsatisfactory discharge planning. Findings: During a review of Resident 1's Admission Record (AR 1), the AR 1 indicated, the facility last admitted Resident 1 to the facility on [DATE], with multiple diagnoses including wedge compression fracture (fracture of the spine, in the front of the vertebra [small circular bones that form the spine]) of T11-T12, history of falling, abnormalities of gait (manner of walking) and mobility, and age-related osteoporosis (bones become thinner and more likely to break with aging). During a review of Resident 1's History and Physical Examination (H&P 1), dated [DATE], the H&P 1 indicated, Resident 1 was able to make needs known but not able to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS 1, a standardized resident screening and care-planning tool), dated [DATE], the MDS 1 indicated Resident 1 had moderate impairment in cognition (ability to think, process information, and remember). The MDS 1 indicated Resident 1 was dependent on staff for toileting hygiene, bathing, lower body dressing, putting on/taking off footwear, sit-to-stand, and transfers. The MDS 1 indicated Resident 1 required substantial/maximal assistance with oral hygiene, upper body dressing, and personal hygiene. During a telephone interview on [DATE] at 9:17 AM with Resident 1's responsible party (R1R), R1R stated the facility wanted to discharge Resident 1 from the facility on [DATE], although Resident 1 required custodial care/LTC (performed within a nursing facility to assist with one's activities of daily living [ADL]). R1R stated Resident 1 and family were not provided timely and sufficient assistance with finding placement in LTC facilities certified under Medicaid. During an interview on [DATE] at 12:10 PM with the Director of Nursing (DON), the DON stated Resident 1's Medicare benefits expired on [DATE], but the facility was not discharging Resident 1 due to no placement found in a LTC facility certified under Medicaid. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 1:31 PM with the DON, Resident 1's social services notes, nursing notes, care plan meeting notes, hospital inquiry, and discharge care plan were reviewed. The DON stated there was no updated individualized discharge care plan for Resident 1 that indicated placing Resident 1 in a Medicaid-certified LTC facility. The DON stated there was no documented evidence of Resident 1's referrals to any Medicaid-certified LTC facilities made by the facility's social services department and the LTC facilities' responses. During a concurrent interview and record review on [DATE] at 8:42 AM with the Social Services Director (SSD), Resident 1's social services notes and SSD notes were reviewed. The SSD stated the SSD sent referrals to multiple LTC facilities, which either denied Resident 1's admission or were refused by R1R. The SSD was unable to provide documented evidence of referrals made to Medicaid-certified LTC facilities for Resident 1. The SSD stated upon Resident 1's admission, the plan was for Resident 1's responsible party to look for placement. The SSD stated the SSD referred Resident 1's responsible party to a third-party individual, who worked for hospice care and had a relationship with Senior Homes to help find placement for Resident 1. During an interview on [DATE] at 9:41 AM with the Director of Rehabilitation (DOR), the DOR stated the facility provided R1R with many options for Medicaid-certified facilities for LTC but had not agreed to sign up Resident 1 to any of the LTC facilities provided to R1R. During an interview on [DATE] at 2:42 PM with the DON, the DON stated complete, accurate, and timely documentation of the referrals made to Medicaid-certified LTC facilities and any assistance provided by the facility to Resident 1 was important to show that the facility helped Resident 1 and/or R1R as much as possible to ensure a safe discharge from the facility. During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services, dated , d+[DATE], the P&P indicated, social services personnel coordinated most resident referrals with outside agencies, unless emergency or specialized services must be arranged directly by the physician or the nursing staff. The P&P indicated, social services documented the referral in the resident's medical record. The P&P indicated, social services and administration maintained a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs. A review of the facility's P&P titled, Social Services, dated ,d+[DATE], the P&P indicated, the facility provided medically related social services to assure that each resident attained or maintained his/her highest practicable physical, mental, or psychosocial well-being. The P&P indicated, the social services department was responsible for compiling up-to-date information about community health and service agencies available for resident referrals, making referrals to social service agencies as necessary and appropriate, maintaining appropriate documentation of referrals and providing social service data summaries to agencies, maintaining contact with the resident's family members, involving them in the resident's total plan of care, and participating in the planning of the resident's transfer to another facility by assessing the impact of these changes and making arrangements for social and emotional support.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire San Dimas Post-Acute	1740 S San Dimas Ave San Dimas, CA 91773

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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 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. 36288 Based on interview and record review, the facility failed to maintain an accurate and complete medical record for one of three sampled residents (Resident 2) when the facility did not accurately document Resident 2's legal decisionmaker/representative (R2R) on Resident 2's admission record. This failure had the potential to cause a delay in providing the care and services for Resident 2 related to the undocumented decision-making capacity of R2R regarding Resident 2's care. Cross Reference F661 Findings: During a review of Resident 2's Admission Record (AR 2), the AR 2 indicated, the facility initially admitted Resident 2 on 5/20/2024, with multiple diagnoses including cerebral infarction (ischemic stroke- disrupted blood supply to the brain, causing tissue death) with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side, aphasia (language disorder affecting person's ability to understand and speak language), gait (manner of walking) and mobility abnormalities, muscle wasting (thinning of muscle mass) and atrophy (loss of muscle mass and strength), and need for assistance with personal care. The AR 2 indicated, Resident 2 was self-responsible. During a review of Resident 2's History and Physical Examination (H&P 2), dated 5/20/2024, the H&P 2 indicated, Resident 2 was able to make needs known but could not make medical decisions. During a review of Resident 2's Minimum Data Set (MDS 2- a standardized resident assessment and care-planning tool), dated 5/27/2024, the MDS 2 indicated, Resident 2 had absence of spoken words, had difficulty communicating some words or finishing thoughts but was able to if prompted or given time, and would miss part/intent of the message but would comprehend most of the conversation. The MDS 2 indicated, Resident 2 had some difficulty making decisions regarding tasks of daily life in new situations only. The MDS 2 indicated, Resident 2 was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. The MDS 2 indicated, Resident 2 required substantial/maximal assistance with oral hygiene, upper body dressing, personal hygiene, and mobility. During a review of Resident 2's Physician Order (MDO 1), dated 7/9/2024, timed at 6:29 PM, the MDO 1 indicated, an order to discharge Resident 2 to home with Home Health (unspecified) on 7/9/2024. The MDO 1 indicated, Resident 2 may have home health PT/OT & registered nurse (RN) for safety evaluation to follow. The MDO 1 indicated, Resident discharged home with family at 5:40 PM. During a telephone interview on 7/17/2024 at 2 PM with R2R, R2R stated Resident 2's discharge came as a total surprise. R2R stated R2R did not think Resident 2 was ready for discharge from the facility. R2R stated no home health RN, OT, PT visits were arranged. R2R stated R2R tried to call Resident 2's health insurance company (HIC), but the HIC staff would not talk to R2R and release any information, stating the HIC staff would need to speak with Resident 2. R2R stated R2R needed to explain to HIC staff that Resident 2 was nonverbal, and R2R had the Power of Attorney documents on file as she was the legal decisionmaker for Resident 2. R2R stated R2R was frustrated due to the runaround. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	07/18/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/17/2024 at 2:50 PM with the Director of Nursing (DON), the AR 2 and Resident 2's POA documents were reviewed. The DON stated the AR 2 needed to be updated to reflect R2R as Resident 2's responsible party to prevent any confusion regarding the decisionmaker for Resident 2's care. During a review of the facility's policy and procedure (P&P) titled, Charting Errors and/or Omissions, revised 12/2006, the P&P indicated, accurate medical records shall be maintained by the facility.