

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555804 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY COMPLETED<br><br>07/31/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Victoria Post Acute Care |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>654 S. Anza<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
|--|--|
| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</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:<br><br>555804  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY COMPLETED<br><br>07/31/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Victoria Post Acute Care   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>654 S. Anza<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure a safe and orderly discharge and continuum of care, for one of three residents (Resident 1), when Resident 1 was discharged to a homeless shelter that was closed and not accepting any admissions for the evening, when reviewed for discharges. This failure resulted in Resident 1 not having a place to sleep or have supervision for the evening of his discharge. Findings: An unannounced visit was made to the facility on 7/31/25, in regard to a complaint regarding an unsafe discharge. Per the complainant, when Resident 1 arrived at the homeless shelter, they were closed for the evening. The resident had no place to go and later presented himself to the emergency room department. Resident 1 was admitted to the facility on [DATE], with diagnoses which included need for assistance with personal care and abnormal gait and mobility, per the facility's admission Record. Resident 1's medical record was reviewed on 7/31/25. According to the care plan, titled Discharge, dated 7/9/25, Resident 1 wished to return/be discharged to the community. Interventions included establishing a pre-discharge plan with the resident, home health or outpatient rehabilitation to be arranged for continuity of care, make arrangements with required community resources to support resident, and needs written instructions. According to the physician's History &amp; Physical, dated 7/10/25, Resident 1 had the capacity to understand and make decisions. According to the Physician's order, dated 7/10/25, discharge to shelter vs Independent Living Facility. According to the Case Manager notes, dated 7/15/25, Met with resident to inform of new MD (medical doctor) order and last covered day 7/15/25, related to health plan provided. Resident declined to appeal and will proceed with discharge to community resource vs independent living facility placement on 7/16/25. Resident offered placement resources and homeless shelters and declined. Resident declined transportation. According to the Case Manager notes, dated 7/16/25, Resident 1 and brother refusing to choose a homeless shelter and transportation. Resident requested name of homeless shelters in El Cajon, stating he wanted to discharge today. According to the nurse's note, dated 7/16/25 at 2:55 P.M., Resident discharged to community of choice, declined transportation. All medications and belongings were given to resident. An interview and record review was conducted with Case Manager Assistant (CM-A) on 7/31/25 at 12:41 P.M. The CM-A stated she tried to work with Resident 1 and his brother, regarding placement multiple times. The CM-A stated they had a plan for a shelter discharge, but the day before discharge, the resident declined and said he would find something on his own. The CM-A stated on the day of discharge, she provided the name and address of a local shelter, that the resident could walk to, because he refused transportation. The CM-A stated the resident left their facility around 5 P.M., and was instructed bed assignments at the shelter closed at 6 P.M. On 7/31/25 at 12:49 P.M. the CM-A called the homeless shelter she referred Resident 1 to. The call was placed on speaker phone. The Shelter (name) stated they only accept clients from 8 A.M. to 4 P.M. The representative stated after 4 P.M., the doors are locked and no admittance was allowed. The CM-A stated she was unaware the shelter closed at 4 P.M. and she should have called the shelter first to confirm there was a bed, and what time they closed before she sent Resident 1 there. The CM-A stated since the resident was not agreeable to the previous arrangements, she should have signed the resident out AMA (against medical advice), since the discharge was not safe and organized. The lead Case Manager was unavailable for an interview. An interview and record review was conducted with the Social Service Director (SSD) on 7/31/25 at 12:56 P.M. The SSD stated the Interdisciplinary Team (IDT-when department heads meet to discuss resident issues), met on 7/15/25, and had Resident 1's discharge planned to a specific shelter, with follow up care of home health, physical therapy, and occupations therapy. After all the arrangements were made, Resident 1 announced he wanted to select his own homeless shelter and he refused transportation. The SSD stated she had no further more involvement in the discharge plan, because he was considered a short-term resident and the Case Managers were doing all the discharge planning for short term residents. The SSD stated if Resident 1 refused the discharge recommendations, it was his right, but staff should have signed him out as AMA and not a planned discharge. An interview was conducted with Licensed Nurse 1 (LN 1) on 7/31/25 at 1:06 P.M. LN 1 stated it was important for resident's being discharged to have a place to go for continuity of care. LN 1 stated all residents should have a discharge summary, MD orders, home health services such as physical therapy, medications and follow up care, along with transportation. LN 1 stated if the discharge cannot be conducted safely and orderly, and the resident was not agreeable to the recommendations, then the</p> |  |  |