STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	**03/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	**510 E. WASHINGTON AVENUE 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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe discharge plan was provided for 1 of 3 residents (1) reviewed for discharge planning. This failure put Resident 1 at risk for harm when he was discharged to a lower level of care without required evaluation. Findings: According to the Resident Face Sheet, Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On [DATE], a record review for Resident 1 was conducted. Resident 1 had a progress note dated 10/02/19 at 11:40 P.M. This progress note stated Resident 1 was observed yelling and verbalized delusions. On 10/03/19, Resident 1 had a doctor's order for Resident 1 to be sent for evaluation in a behavioral health unit. The Resident Census recorded Resident 1 left the facility for Hospital Leave on 10/03/20 at 1:37 P.M. On 10/11/19 at 7:30 P.M., a progress note documented Resident 1 returned from his stay in the behavioral health unit. On 10/11/19 at 7:50 P.M. (30 minutes later), a progress note stated Resident 1 was heard yelling in his room and hit a nurse hard on the back of the neck. According to the same progress note, a physician's orders [REDACTED]. A progress note, dated 10/12/19 at 1:30 A.M., documented Resident 1 returned from the hospital (he was not admitted to the behavioral unit). This progress note stated Resident alert and oriented x 1 (Resident 1 knew who he was, but not where he was or the time it was) with episodes of confusion .Resident is in a private room with 1:1 male CNA (Resident 1 was given continuous supervision). The next progress note, dated 10/12/19 at 12:23 P.M., LN 1 documented Resident 1 was to be discharged to an assisted living facility, according to MD (medical doctor) orders and Resident 1's request. Resident 1's medical chart contained an order, dated 10/12/19, Discharge to assisted living per resident's request . The Resident Census recorded Resident 1 was discharged on [DATE] at 2:25 P.M. During the record review, Resident 1's care plan for discharge was reviewed. Resident 1's discharge care plan, dated 9/3/19, stated discharge plans could not be determined at that time. The only listed goal for Resident 1 was to adjust to long-term skilled nursing home placement. Resident 1's care plan was not updated prior to discharge. On 1/22/20 at 8:45 A.M, an interview was conducted with SS1. SS1 stated she was the social worker who arranged Resident 1's discharge. SS1 stated Resident 1 wanted to be discharged from the facility and so she arranged it. SS1 stated she did not speak with Resident 1's doctor regarding his discharge. SS1 stated she did not look at or update Resident 1's discharge care plan. She stated Resident 1 did not have a psychological assessment performed at the facility prior to discharge. SS1 stated she did not review Resident 1's recent behavioral health discharge information prior to arranging his discharge. SS1 stated that though Resident 1 had been combative the night before, he was not combative at the time of discharge; therefore, it was appropriate to discharge him. SS1 stated, I thought if we discharged him, he would do better mentally. On 1/22/20 at 10:20 A.M., an interview was conducted with LN 1. LN 1 stated she was the nurse supervisor the day Resident 1 was discharged . LN 1 stated she requested and received orders from Resident 1's doctor to discharge him. LN 1 stated Resident 1's doctor did not question the request to discharge the resident. LN 1 stated Resident 1's doctor did not evaluate him prior to discharge. On 1/22/20 at 3:20 P.M., a joint interview was conducted with the DON and the Administrator. The Administrator questioned whether the facility was responsible to care for residents who were violent. The DON stated sometimes discharges happen quickly. He stated, You can't always have a care plan, and IDT (interdisciplinary team) meeting, or a doctor's evaluation. The DON stated safe discharge planning should include involving the resident's family members. On 1/31/20 at 2:45 P.M., an interview was conducted with Resident 1's family member. The family member stated she had not been consulted prior to Resident 1 being discharged from the facility and she was not even told where he was discharged to. The facility's policy titled Transfer/Discharge did not address discharges to a lower level of care, such as assisted living situations.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide diabetic care for 1 of 2 residents (1) reviewed for diabetes treatment. This failure put Resident 1 at risk for uncontrolled diabetes, which can lead to kidney failure, loss of sight, and heart failure. Findings: According to his Face Sheet, Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 1/31/20 at 11:47 A.M., an interview with Resident 1's family member was conducted. The family member stated Resident 1 had diabetes and needed help to keep it under control. On 3/12/19, a record review was conducted for Resident 1. Resident 1's [DIAGNOSES REDACTED]. A doctor's H&P dated 9/[DATE]9 lists DM (abbreviation for diabetes mellitus), no [DIAGNOSES REDACTED] as one of Resident 1's medical diagnosis. A review of Resident 1's physician's orders [REDACTED]. During the same record review, Resident 1's blood sugar levels were reviewed. On 8/23/19 at 10:47 A.M., Resident 1 had a blood sugar of 238 documented (normal blood sugar is below 140). A progress note written on 8/23/19 at 9:30 A.M., documents Resident 1 was transferred to the hospital for treatment following this single elevated blood sugar. No other documentation was found to show Resident 1's blood sugar had been monitored throughout his care at the facility, prior to or after this incident occurred. During the same record review, dietitian progress notes were reviewed. The registered dietitian (RD) wrote notes concerning Resident 1's diet on 8/21/19. There was no mention of Resident 1 requiring a diabetic diet. On 3/12/19 at 2:45 P.M., a joint interview and record review was conducted with LN 2. LN 2 stated he had regularly cared for Resident 1. LN 2 stated all diabetic residents should have had orders from their physician to monitor their blood sugar. LN 2 was unable to find any orders for Resident 1 to have his blood sugar monitored. LN 2 found only one record of Resident 1's blood sugar being checked, dated 8/23/19. LN 2 stated it was important for diabetics to have their blood sugar monitored on a regular basis. LN 2 stated blood sugar too low or two high could have negative effects on a resident, such as changes in level of consciousness or combativeness. During the joint interview and record review, LN 2 was unable to find any notes from the RD that discussed a plan for Resident 1 to have a diabetic diet. LN 2 was unable to find any orders from Resident 1's physician ordering a diabetic diet. LN 2 stated Resident 1 did not receive diabetic care at the facility. LN 2 stated staff at the facility should have noticed Resident 1 was diagnosed with [REDACTED]. According to the facility's policy, Diabetes-Clinical Protocol, revised December 2015: .The physician and staff will summarize factors that are contributing to .the resident's diabetes .4. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.