STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056362	A. BUILDING _____ B. WING _____	**09/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA VERDE POST ACUTE CARE CENTER	**661 CENTER STREET COSTA MESA, CA 92627**

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, medical record review, and facility P&P review, the facility failed to ensure a discharge planning process was in place for one of two closed sampled residents (Resident 1). The facility failed to ensure Resident 1's discharge plan needs were assessed, reevaluated, and provided prior to discharge. This failure posed the risk for an unsafe transition from the facility to home with a family member who had not planned to take the resident home. Findings: Review of the facility's P&P titled Transfer and Discharge revised 7/2/2020, showed the facility will ensure adequate preparation and assistance is provided to residents prior to discharge from the facility. On 7/30/2020 at 1230 hours, a telephone interview was conducted with the complainant. The complainant stated the facility was aware of the discharge plans for Resident 1 who was to be discharged to an assisted living facility (ALF). The complainant stated the facility notified her of the upcoming discharge date for Resident 1, and when the complainant was asked where Resident 1 was going to be discharged , the facility stated they had no where to discharge Resident 1 to. The complainant stated they took Resident 1 into their home. Closed medical record review for Resident 1 was initiated on 8/4/20. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's H&P examination dated 5/8/2020, showed Resident 1 was unable to make medical decisions by himself. Review of Resident 1's physician orders [REDACTED]. There was an order for [REDACTED]. Review of Resident 1's Physician Discharge Summary dated 6/20/20, showed Resident 1 was discharged home. The note showed Resident 1's health had improved sufficiently and the resident had no longer needed the services provided by the facility. Review of Resident 1's Notice of Proposed Transfer and discharge date d 6/20/20, showed the discharge was necessary for the resident's welfare, and his needs could not be met in the facility. Review of Resident 1's Post Discharge Plan of Care dated 6/20/20, showed Resident 1 was discharged home and the section post discharge plans or community agencies was blank. Review of Resident 1's medical record failed to show any social services assessment or notes. Review of Resident 1's Baseline Care Plan Summary dated 4/14/2020, showed the social services were to assist with the discharge planning to return to the group home. There was no documentation to show the resident was to be discharged to a family member's home. Review of Resident 1's care plan titled discharge date d 4/14/20, showed Resident 1 wanted to be discharged home, and the resident might need assistance to coordinate out of town discharge. The interventions included to coordinate with the local contact agency, arrange the family conference to establish the discharge plan, arrange with scheduling of the post-discharge appointments and services as needed for the resident's durable medical equipment, transportation, home health services, and follow up with the resident or family to assure understanding of plan or answer additional questions. On 8/14/2020 at 1204 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the SSD. The SSD stated the initial plan was to discharge the resident back to the group home, but the group home would no longer accept him. The SSD stated they referred Resident 1's family to a placement agency that would assess and assist the resident into a residential care facility. The SSD stated she obtained the consent from Resident 1's family to disclose the information to the placement agency. The SSD stated she notified the nursing staff to assist the physician with completing the physician's assessment form which was needed by the placement agency and residential care facility in order for Resident 1 to be evaluated and properly placed. The SSD verified the physician's report for the residential care facility was not completed or signed by the physician prior to discharge. The SSD verified there was no follow up conducted to ensure this was done. When asked if she assisted Resident 1's family with the referrals or AFL, the SSD stated she was not sure. On 9/3/2020 at 1454 a follow-up telephone call was conducted with the SSD. The SSD verified she was contacted by a second placement agency to obtain a placement waiver for Resident 1 in order to help in placing Resident 1 into an AFL. The SSD stated she did not remember when she last interacted with the second placement agency or what was discussed. The SSD verified Resident 1's medical record did not show documentation of any social services notes or assessments.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure two of two closed sample residents (Residents 1 and 2) were provided with complete discharge instructions. * Resident 1's Post Discharge Plan of Care failed to show documentation for the medications Resident 1 was prescribed upon discharge and failed to show documentation for the name of the home health agency or contact information. In addition, there was no documentation of the name and contact information for a primary care doctor or endocrinologist. * Resident 2's Post Discharge Plan of care failed to show documentation for the name and contact information of the home health agency. These failures posed the risk for Residents 1 and 2 not having the necessary care and services to after being discharged from the facility. Findings: Review of the facility's P&P titled Transfer and discharge date d 7/2/2020, showed referrals made to local agencies will be documented in the medical record and preparations for and assistance with discharge planning will be documented in the medical record as well. In addition, social services staff will document the discharge planning, preparation, and the resident's post discharge needs. 1a. Closed medical record review for Resident 1 was initiated on 8/4/2020. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had a moderate cognitive impairment. Review of Resident 1's Physician and Telephone Orders showed a physician order [REDACTED]. The order included to follow up with the resident's primary physician and endocrinologist and for home health agency to follow the resident and medications. Review of Resident 1's Post Discharge Plan of Care dated 6/20/2020, failed to show the physician's orders [REDACTED].-discharge plan of care. In addition, the documentation failed to include the instructions on the administration of the resident's routine medications, including [MEDICATION NAME] (antidiabetic), [MEDICATION NAME] (antihypertensive), and [MEDICATION NAME] (for mood disorder). Review of Resident 1's Discharge Summary/Comprehensive Summary dated 6/20/2020, did not show the summary was provided to Resident 1's Responsible Party 1. On 8/14/2020 at 1204, a telephone and concurrent closed medical record review for Resident 1 was conducted with the SSD. When asked about the facility's discharge process, the SSD stated the physician or the licensed nurses were to let the staff know of any upcoming discharges, and the staff were to assist with the planning. The SSD was asked if she was aware of Resident 1's discharge order. The SSD stated no and did not remember assisting Resident 1 and/or their family with the referrals or home health services prior to discharge. The SSD verified Resident 1's Post Discharge Plan of Care failed to show the contact information for the home health agency, primary care physician, or endocrinologist. The SSD verified the facility failed to have social services assessments or notes for Resident 1. On 8/19/2020 at 1354 hours, an interview was conducted with LVN 1. LVN 1 stated she discharged Resident 1 with a family member on 6/20/2020. LVN 1 was asked if Resident 1 was sent home with home health services, or was provided the information for the primary care doctor or

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056362	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA VERDE POST ACUTE CARE CENTER	661 CENTER STREET COSTA MESA, CA 92627

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 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) endocrinologist. LVN 1 stated she did not recall. On 9/4/2020 at 1025 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON stated once the staff obtained a physician's orders [REDACTED]. The DON stated the licensed nurses were to provide the resident and/or responsible party instructions regarding any care, medications, and referrals. The DON stated any additional referrals or information for appointments after discharge would be provided by the social services staff. The DON verified Resident 1 had no documentation for referrals to the home health agency and primary care physician or endocrinologist. The DON stated the information should have been documented to provide Resident 1 and his family member. b. Review of Resident 1's medical record, showed the following physician's orders [REDACTED]. * 5/29/2020, for [MEDICATION NAME] 500 mg two tablets by mouth at bedtime for mood and sleep. * 6/4/2020, start [MEDICATION NAME] 10 mg daily. Review of Resident 1's Post Discharge Plan of Care dated 6/20/2020, failed to show the above medications were included. 2. Closed medical record review for Resident 2 was initiated on 8/4/2020. Resident 2 was readmitted to the facility on [DATE], with diagnoses, including diabetes mellitus and difficulty walking. Review of Resident 2's closed medical record showed a physician's orders [REDACTED]. The discharge order included to ensure the arrangements were made for a wheelchair with bilateral foot rests and a commode, home health services for physical therapy and RN for evaluation and treatment. Review of Resident 2's Discharge Summary/Comprehensive assessment dated [DATE] failed to show documentation of the name and contact information for the home health agency. On 9/4/2020 at 1025 hours, a telephone interview, and concurrent closed medical record review for Resident 2 was conducted with the DON. The DON verified there were no documentation for referrals for home health services.
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 medical record review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of two sampled residents (Resident 1). The facility failed to ensure to follow up and reschedule Resident 1's medical appointments. These failures created the risk of staff not providing appropriate continued care. Findings: Closed medical record review was initiated on 8/4/20. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's closed medical record showed a physician's orders [REDACTED]. Review of Resident 1's licensed nurses' notes dated 5/10 and 5/13/2020, showed Resident 1 had episodes of restlessness, anxiety, agitation, and wandering, requiring the medical interventions. On 8/14/2020 at 1204 hours, an interview and concurrent closed medical records [REDACTED]. The SSD stated the licensed nurses were responsible for scheduling the residents' appointments outside the facility. The SSD dated the social services staff was responsible for arranging the transportation to the appointments. The SSD stated Resident 1 did not have an appointment on 5/13/20, because of his change in condition. On 9/8/2020 at 1037 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON was asked about Resident 1's appointment for 5/13/2020. The DON stated the resident had a change in condition and was not stable to go to his appointment, so the appointment was canceled. The DON verified there were no documentation to show the nurses had made an attempt to reschedule Resident 1's appointments.
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** Based on interview and medical record review, the facility failed to ensure the discharge records for one of two closed sampled residents (Resident 1) was complete and accurate. * Resident 1's Physician Discharge Summary and Notice of Proposed Transfer and Discharge form was incomplete and showed different reasons for discharge. * Resident 1's Discharge Summary/Comprehensive Assessment and Resident Transfer Record showed different assessments for Resident 1's functional status. * Resident 1's Resident Inventory sheet was not signed by the resident or the resident's family on discharge. These failures had the potential for the residents' care needs not being met as the medical information was incomplete and inaccurate. Findings: Closed medical record review for Resident 1 was initiated on 8/4/18. Resident 12 was admitted to the facility on [DATE] and discharged on [DATE]. a. Review of Resident 1's Physician Discharge Summary dated 6/20/2020, showed the discharge was necessary due to the resident's health had improved sufficiently and the resident had no longer needed the services provided by the facility. Review of Resident 1's Notice of Proposed Transfer and Discharge form showed where the resident was being discharge to was blank. In addition, the reason for the discharge was different than what the physician's orders [REDACTED]. The DON verified the above findings and stated the licensed nurse should have completed the Notice of Proposed Transfer and Discharge. b. Review of Resident 1's Resident Transfer Record dated 6/20/2020, showed Resident 1 was independent in bathing, dressing, eating, transfers, and ambulation. In addition, Resident 1 required assistance in personal hygiene. However, review of Resident 1's Discharge Summary/Comprehensive assessment dated [DATE], showed Resident 1 needed assistance in bathing, dressing, eating, personal hygiene, bed mobility, and toilet use. Resident 1 was independent in transfers and ambulation. On 9/4/2020 at 1025 hours, a telephone interview and concurrent closed medical record review was conducted with the DON. The DON verified the above findings and stated the licensed nurse should have reviewed the Discharge Summary before discharging the resident. c. Review of Resident 1's Resident Inventory record showed an admitted on 4/14/2020, with an initial inventory of one jeans, one shirt, one belt, and 1 pair of socks. The receipt section was left blank. On 9/8/2020 at 1037 hours, a telephone interview and concurrent closed medical record review was conducted with the DON. The DON verified the Resident Inventory sheet was not signed on discharge and stated it should have been signed on the discharge date .