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 _____	C 08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN DIEGO POST-ACUTE CENTER	1201 SOUTH ORANGE AVE. EL CAJON, CA 92020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		9/8/23

The following reflects the findings of the California Department of Public Health during an abbreviated standard survey.

Facility Reported Incident Number: CA00853634
Category: Quality of Care

Representing the Department: Health Facilities Evaluator Nurse(s): 46247

The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility.

One deficiency was issued for the Facility Reported Incident: CA00853634 (Refer to Ftag 689).

F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to implement measures to keep a resident (Resident 1) safe from elopement (leaving the facility without permission).

As a result, Resident 1 eloped and had not been

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/8/2023

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.

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F 689	Continued From page 1 found.	F 689		9/8/23

Findings:

Resident 1 was admitted to the facility on 6/1/23 with diagnoses that included depression and schizoaffective disorder (a condition that causes hallucinations and dramatic mood changes), per the facility ' s Admission Record.

A review of Resident 1 ' s care plan, dated 6/3/23, indicated Resident 1 was at risk for elopement related to episode of exit seeking and leaving facility. The care plan did not indicate staff or visitor to check and sign in the log before taking the resident and after dropping the resident off.

On 8/2/23 at 9:38 A.M. an interview was conducted with certified nursing assistant (CNA) 1. CNA 1 stated Resident 1 had been placed in a room on station 1 (S1, a secured and alarmed unit for residents at risk of wandering) because she was frequently trying to leave the facility. CNA 1 stated Resident 1 left S1 for a scheduled appointment on 7/31/23 at 1:00 P.M. with Resident 1 ' s responsible party (RP, person who is designated to be responsible for a resident.) CNA 1 stated it was facility policy for both the nurse and the RP to sign residents in and out of S1 when taking the resident out of the building. CNA 1 stated if Resident 1 ' s nurse and Resident 1 ' s RP signed Resident 1 in and out of the building on 7/31/23, it would be documented in the "Leave of Absence (LOA) binder. CNA 1 stated the doors to S1 were not locked.

On 8/2/23 at 10:13 A.M. an interview and record review were conducted with licensed nurse (LN) 1. LN 1 stated Resident 1 has tried to open exit

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	555659	A. BUILDING _____ B. WING _____	C 08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 2	F 689		9/8/23

doors and elope from the facility in the past. LN 1 stated Resident 1 was supposed to return from her appointment on 7/31/23 at 6:00 P.M. but had not returned. LN 1 stated an authorized RP, and an LN were required to sign-in and sign-out all residents on S1 when picking them up and dropping them off for appointments. LN 1 stated in addition to the exit alarm Resident 1 had a wanderguard (WG - an alarm device attached on body) on her left ankle. A review of Resident 1 ' s elopement care plan was conducted with LN 1. Resident 1 ' s care plan, dated 6/9/23 indicated Resident 1 ' s WG was to have placement and functionality checked every shift. LN 1 stated she did not know if Resident 1 ' s WG was working when Resident 1 left for her appointment on 7/31/23 because she had not checked the placement or functionality of Resident 1 ' s WG during her shift. LN 1 stated the facility had not educated her on how to check the functionality of a WG and she did not know the steps to complete this task.

On 8/2/23 at 10:49 P.M. a concurrent interview and record review was conducted with LN 1 and LN 2. A review of Resident 1 ' s sign-out/sign-in sheet titled, Temporary Out on Pass Form," for the month of July 2023 was conducted. The record indicated a nurse had not signed Resident 1 in or out for the following dates she left the facility in July 2023: 7/3, 7/5, 7/8, 7/9, 7/10, 7/15, 7/16, 7/17, 7/21, 7/22, 7/23, 7/25, 7/28, 7/31/23. LN 2 stated residents on S1 are required to have an LN sign the resident in and out of the facility.

On 8/2/23 at 12:45 P.M., an interview and record review with the director of staffing development (DSD) was conducted. The DSD stated an elopement binder was kept at the front desk with

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F 689	Continued From page 3	F 689		9/8/23

names and pictures of residents at risk for elopement (leaving the facility). The DSD stated any resident with a WG was required to be listed in the binder. A review of the elopement binder was conducted with the DSD. The elopement binder did not indicate a listing of Resident 1 ' s name or picture. The DSD stated if Resident 1 had a WG her name and picture should be in the elopement binder.

On 8/25/23 at 1:17 P.M. a telephone interview was conducted with the director of nursing (DON). The DON. The DON stated it was expected that LN ' s sign a resident in and out on the designated log when leaving and returning to the facility. The DON stated if nurses did not sign the resident in and out it would not be following best practice and policy. The DON stated staff should know how to check for WG placement and functionality.

A review of the facility policy titled, Signing Residents Out, revised August 2006 indicated, "Policy Statement: All residents leaving the premises must be signed out. Policy Interpretation and Implementation 1. Each resident leaving the premises (excluding transfers/discharges) must be signed out. 2. A sign-out register is located at each nurses ' station ... 6. Staff observing a resident leaving the premises and having doubts about the resident being properly signed out, should notify their supervisor at once. ..."

A review of the facility policy titled Review for Elopement Risk; Wandergaurd Placement, undated, indicated, " ...Policy: It is the policy of this facility to provide patients who are at risk for wandering, eloping, and/or exit seeking a safe

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F 689	Continued From page 4	F 689		9/8/23

environment and allow them to maintain their highest practicable level of well-being ... Procedure ... 6. Social Services to update elopement binder (s) with patient ' s demographics sheet, to include picture of patient ... 9. Licensed Nurse to check placement and function of Wanderguard every shift. Licensed nurse to use device tester and/or take patient to an exit door. If device is not working the device will be replaced immediately."

F 689 Free of Accident Hazards/Supervision/Devices

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 1 no longer resides in the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents that leave the facility for a temporary leave of absence (LOA) have the potential to be affected. All residents that went out on pass during the last 30 days were reviewed on 8/29/2023. No other residents were found to be affected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

LN 1 was provided individualized education regarding how to check the placement and functionality of a wander guard by the Station 1 Unit Manager on 8/2/23.

LNs, CNA's, Ward clerks were in-serviced on the facility policy for Signing Residents Out and the Facility Elopement Policy including how to check the placement and functionality of a wander guard on 8/29/2023 by Director of Staff Development.

The facility LOA binders were updated on 9/6/23.

The Temporary Out on Pass form was revised to include the contact information or the Responsible Party (RP). The following information will be recorded on the leave of absence log prior to the resident leaving:

- The resident's name.
- Date.
- Time out.
- Destination
- Scheduled return time.
- Name of the party responsible and contact information.
- Time returned.

The LN will be responsible for documenting in the LOA log what time the resident returns safely to the facility.

The Unit Managers will audit documentation in the LOA log and findings will be reported to the Administrator and to the Director of Nursing during the Monday to Friday stand up meetings

On weekends and holidays, the Charge Nurse will review documentation in the facility Leave of Absence Log and findings will be reported to the Administrator or Director of Nursing.

Staff found to be not completing documentation will be re-educated by DON. Audits would continue for 3 months or until 100% compliance is achieved.

How the facility plans to monitor its performance to make sure the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:

The Director of Nursing (DON) will monitor for compliance. Any findings and trends will be reported at the monthly Quality Assurance Committee Meeting for the next 3 months. The Administrator will monitor and ensure compliance is achieved by the QAPI (Quality Assessment and Performance Improvement) Committee. Compliance goal: 100%

Completion date: 9/27/23

San Diego Post Acute In-Service Sign In Sheet

ubject: Resident Sign in/out form / Mandatory placement
acility Provider Name: San Diego Post Acute
nstructor Name: Hagop Ponares D.O.P Signature:
ate: 8/29/23 Begin: 1100 End: 1200 Length: 1HR
lethod of Training/In-Service: Lecture Q&A

	Print Name and Title	CNA Certificate Number	Signature
1	Itzel Reyes	CNA	
2	Karina SanJuan	CNA	
3	Maria E. Robledo		
4	GABRIELA NEGRETE A.	CNA	
5	LEAN PAOLO EBALO, LVN		
6	Ruth S-Cruz	CNA	
7	IRMA COIRE	CNA	
8	Christine Lumibao	CNA	
9		CNA	
10	Arian Salvador	CNA	
11	Janine Cabrera	LVN	
12	Rommel Forones	CNA	
13	Tita Ballo Way	LVN	
14	Samantha Sanchez	CNA	
15	Shielyn B. LVN	LVN	
16	Francis C.	LVN	
17	Socorro Herras	LVN	
18	Saradjine Jeune RN	RN	
19	Selida Garcia	CNA	SKG
20	Vivian Lopez	CNA	
21	Louise Malsh	LVN	
22	Megan Hardy	LVN	
23	Regine N.	CNA	
24	Chardonnay Trent	LVN	
25	Stacey Offedahl	CNA	
26	Jonathan Sayson	LVN	
27	Michael Cerros	LVN	

San Diego Post Acute In-Service Sign In Sheet

ubject: Resident sign in/out form / Wanderguard placement
acility Provider Name: San Diego post acute center
nstructor Name: Heyan Parrales Signature:
ate: Begin: 10a End: 11a Length: 1hr
lethod of Training/In-Service: lecture Q & A

	Print Name and Title	CNA Certificate Number	Signature
1	Kimberlie Fontanilla LVN		
2	Thu Hoa Tran Bui		
3	Donna Whitlow		
4	Tyana Warsaw		
5	Malcolm Marendunn		
6	Ramon Del Castillo		
7	Heyan Parrales	LVN	
8	Marlon Fonseca	LVN	
9	Chris Bracy	CNA	
10	Dianna A	CNA	
11	GERARDO LABRADO	CNA	

TEMPORARY OUT ON PASS FORM

I, the undersigned, do hereby request the privilege of taking the listed resident temporarily out on pass from the premises of San Diego Post-Acute. I hereby specify the time of departure, destination, and anticipated time of return. I hereby agree to assume all responsibility for the listed resident, and promise and agree not to hold San Diego Post-Acute, its personnel or attending Physician in any way responsible or liable in case of an accident or any other incident involving this resident while away from the facility.

MD ORDER IN PLACE: YES / NO **Licensed Nurse Signature:**_____

Date	Time-Out	Destination	Scheduled Return Time	Name of Responsible Party	Signature of Responsible Party	Nurse Initial	Time Returned	Signature of Responsible Party/Nurse	PHONE NUMBER

Name of Resident: (Last, First)	Attending Physician	Room No./Bed:	Medical Record No.

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

August 29, 2023

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Jason Collier, Administrator
San Diego Post-Acute Center
1201 South Orange Ave.
El Cajon, CA 92020-7521

Dear Administrator:

On August 28, 2023, an Abbreviated survey for Facility reported incident no. CA00853634 was conducted at your facility by the California Department of Public Health, Center for Health Care Quality (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[X] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[ ] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Please submit the POC in the same method in which you received the CMS-2567 (i.e., ePOC, RSS, or mail).

For abbreviated standard surveys conducted in the RSS complaint/FRI survey application, please follow the instructions below for submitting the signed CMS 2567 and POCs to CDPH electronically through RSS.

1. In RSS, select the "Details" tab to review the cover letter and download a copy of the CMS 2567, which you will need to sign and upload in the next step. This will send the signed CMS 2567 back to CDPH electronically, without the need to mail or email it.

2. The "People" tab, "Responsible People" section provides the list of persons at the facility who have access to the investigation and can submit Plans of Correction for deficiencies.

3. The "Incidents" tab lists deficiencies identified that require the submission of a Plan of Correction.

4. To enter a Plan of Correction:
    a. Select the deficiency
    b. Select the blue "Resolve" button
    c. Select the paper clip icon to attach the signed copy of the CMS 2567 with Plan of Correction.
    d. In addition, open a "Comments" field, copy and paste the Plan of Correction into the field. Please enter the Plan of Correction in the "Comments" field only if it is ready to be sent, not a draft in progress, as clicking "Save" will send the Plan of Correction to CDPH.
    e. Select Save

5. If there are multiple deficiencies, repeat the steps above for each deficiency.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by **September 28, 2023**.

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by **September 28, 2023,** include the following:

[X] A civil money penalty will be recommended to CMS Regional Office if substantial compliance has not been achieved (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on **February 28, 2024,** if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective **November 28, 2023**. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Meriam Cruz, Health Facilities Evaluator Supervisor, California Department of Public Health, Licensing and Certification Program, San Diego District Office 7575 Metropolitan Dr. Suite 211 San Diego, CA 92108. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on **August 28, 2023,** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Donna Loza, RN, California Department of Public Health, Licensing and Certification Program, San Diego District Office 7575 Metropolitan Dr. Suite 211 San Diego, CA 92108.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Meriam Cruz, Health Facilities Evaluator Supervisor, at (619) 278-3700.

Sincerely,

Donna Loza

Donna Loza, RN
District Manager

Enclosure: CMS-2567