STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. BUILDING _____ B. WING _____	**05/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SHORES POST-ACUTE	**2828 MEADOWLARK DRIVE SAN DIEGO, CA 92123**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive plan of care for one of three residents (1) reviewed for care plans, when a surgical wound re-opened and required monitoring. This failure had the potential for Resident 1's foot wound to deteriorate when goals and interventions were not identified or implemented. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 5/5/20, Resident 1's clinical record was reviewed; According to Resident 1's Change of Condition report, dated 4/28/20, Resident 1's surgical site on the right foot, re-opened and created a wound. The right foot wound measured 0.5 centimeters (cm) by 0.5 cm and was draining a small amount of clear fluid. According to Resident 1's physician's orders [REDACTED]. Resident 1's clinical record contained no documented evidence that a care plan had been developed for the opened foot wound. An interview and record review was conducted with Licensed Nurse (LN 2) on 5/5/20 at 1:19 P.M. LN 2 stated care plans were important to identify and treat specific care issues. LN 2 stated Resident 1's clinical record did not indicated a care plan was developed when the surgical foot wound opened, and a plan of care should have been developed to provide consistency in care. An interview with the Director of Nursing (DON) was conducted on 5/5/20 at 1:32 P.M. The DON stated she expected a care plan to be developed or updated with any change of condition. The DON stated care plans were important for consistency of care. According to the facility's policy titled, Goal and Objectives, Care Plans, dated April 2009, .1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem . 5. Goals and Objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; .
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide professional nursing standards of practices for one of three residents (1) reviewed for documentation, when a surgical foot wound had opened and weekly skin assessments were not completed consistently. This failure had the potential for Resident 1's foot wound to deteriorate and for other skin issues to go unrecognized. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses, which included right foot wound, per the facility's Admission record. On 5/5/20, Resident 1's clinical record was reviewed; According to Resident 1's Change of Condition report, dated 4/28/20, Resident 1 Resident 1's surgical site on the right foot, re-opened and created a wound. The right foot wound measured 0.5 centimeters (cm) by 0.5 cm and was draining a small amount of clear fluid. According to Resident 1's physician's orders [REDACTED]. Resident 1's last Weekly Skin Integrity Review was last completed on 4/20/20. There was no documented evidence that a weekly skin assessment had been completed from 4/21/20 through 5/5/20. An interview and record review with Licensed Nurse (LN 2) was conducted on 5/5/20 at 1:19 P.M. LN 2 stated weekly skin assessments were important for Resident 1, since her foot wound was slow in healing. LN 2 reviewed Resident 1's clinical record and stated a weekly skin assessment had not been completed since 4/20/20. LN 2 stated a weekly wound assessment should have been completed after her wound re-opened on 4/28/20, and it had not been. LN 2 stated Resident 1's wound could have worsened since it was re-injured, and a weekly skin assessment wound have captured the wounds improvement or decline. An interview with the Director of Nursing (DON) was conducted on 5/5/20 at 1:32 P.M. The DON stated weekly skin assessments showed overall skin conditions such as improvements or deteriorations. The DON stated LN's should have documented a weekly skin assessment for Resident 1, especially since the toe was re-injured. The DON could not provide a policy on Weekly Skin Assessments.

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.