STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055698	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABBY GARDENS HEALTHCARE CENTER	**8060 FROST STREET 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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform neurological (neuro; referring to the nervous system) assessments (also referred to as neuro checks) after one resident (1) sustained an injury to her head. This failure had the potential to not identify potential decline on resident's neuro status, and result in a delay in treatment and care for Resident 1's needs. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A concurrent observation and interview was conducted on 2/6/18 at 8:26 A.M. with Resident 1. Resident 1 pointed to an injured area on her forehead and stated she had four stitches. A review of Resident 1's SBAR (situation, background, appearance, review) Communication Form dated 1/23/18, was conducted. This record included documentation that Resident 1 sustained a laceration (deep cut or tear in skin or flesh) on her forehead, during a two-person transfer while using a Hoyer lift (equipment used to transfer an individual in and out of the bed or wheelchair). The documentation indicated that the Hoyer lift .tilted causing (the) scale on (the) lift to hit (the) resident on (her) forehead causing a laceration. An interview was conducted with certified nursing assistant (CNA) 5 on 2/6/18 at 9:22 A.M. CNA 5 stated that she and CNA 4 used a Hoyer lift to transfer Resident 1 from her bed to her wheelchair on 1/23/18. CNA 5 stated that during the transfer, the leg (one of the two base supports) of the Hoyer lift tilted and the weight box (scale on the Hoyer lift) also tilted and hit Resident 1 on the head. CNA 5 stated Resident 1's forehead was bleeding. CNA 5 stated she and CNA 4 called for help and licensed nurse (LN) 1 arrived. CNA 5 stated the morning charge nurse (LN 2), .he came to do (an) assessment. An interview was conducted with LN 1 on 2/6/18 at 9:35 A.M. LN 1 stated she was the first LN who responded when the CNAs called for help after the incident happened. LN 1 stated that Resident 1's assigned nurse .was in the area coming and asked for gauze, so I went to get what the nurse needed . that was all. An interview was conducted with LN 2 on 2/6/18 at 11 A.M. LN 2 stated he was the supervisor (charge nurse) on 1/23/18, the morning of the incident. LN 2 stated that when he checked on Resident 1, the nurse was doing an assessment. A review of Resident 1's Neurological Assessment Flow Sheet, dated 1/25/18 was conducted. This record included handwritten schedule of 72-hour neuro check assessments for LNs to be performed at 3 A.M., 7 A.M., 11 A.M., 3 P.M., and 7 P.M. However, each of the assessment boxes were empty. The facility's Neurological Assessment policy, revised July 2015, indicated .Policy . C. Following a . or other accident/injury involving head trauma . II. Neurological checks (neuro checks) will be performed . A. Every 15 minutes for 1 hour, then; B. Every 30 minutes for 1 hour, then; C. Every hour for 2 hours, then; D. Every 4 hours for a combined total of 72 hours . IX. Documentation . The following will be documented in the resident's medical record . A concurrent interview and review of Resident 1's Neurological Assessment Flow Sheet dated 1/23 through 1/25/18 was conducted with the director of nursing (DON) on 2/6/18 at 11:20 A.M. The DON stated that because Resident 1 had a head trauma injury, staff performed neuro checks. The DON further stated the neuro checks should have been performed for 72 hours, through 1/25/18. The DON acknowledged that neuro checks were not performed for a total of 72 hours, per facility policy.
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 record review, the facility failed to ensure one resident's (1) clinical record included complete documentation when: 1. Licensed nurse (LN) signatures were not included in the designated areas of the neurological assessment (also referred to as neuro checks; referring to the nervous system) record. As a result, staff were not able to identify the LNs who completed the neuro checks. 2. Insertion and removal of a Foley catheter (tube inserted into the bladder to drain urine) was not documented in the clinical record. This failure had the potential to result in miscommunication among care providers on necessary care related to the use of the Foley. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. 1. A review of Resident 1's record was conducted. The Minimum Data Set (assessment tool) dated 1/20/18 indicated that Resident 1 had impairment to both of her legs, and used a wheelchair for mobilization (movement). In addition, the assessment indicated Resident 1 was totally dependent (all actions are completed by staff) for transfers. The fall risk care plan dated 7/15/17 included the following intervention: .Use Hoyer lift (equipment used to transfer an individual in and out of bed or wheelchair) with 2 (two) person staff on transfers . The SBAR (situation, background, appearance, review) Communication Form dated 1/23/18, included documentation that Resident 1 sustained a laceration (deep cut or tear in skin or flesh) on her forehead, during a two-person transfer while using a Hoyer lift. The documentation indicated that the Hoyer lift .tilted causing (the) scale on (the) lift to hit (the) resident on (her) forehead causing a laceration. An interview was conducted with certified nursing assistant (CNA) 5 on 2/6/18 at 9:22 A.M. CNA 5 stated that she and CNA 4 used a Hoyer lift to transfer Resident 1 from her bed to her wheelchair on 1/23/18. CNA 5 stated that during the transfer, the leg (one of the two base supports) of the Hoyer lift tilted. CNA 5 stated that when this happened, the weight box (scale on the Hoyer lift) also tilted, and hit Resident 1 on the head. CNA 5 stated she and CNA 4 called for help, and that was when licensed nurse (LN) 1 arrived. CNA 5 stated that another nurse, LN 2, was the charge nurse that morning, and .he came to do (an) assessment. An interview was conducted with LN 1 on 2/6/18 at 9:35 A.M. LN 1 stated she was the first LN who responded when the CNAs called for help after the incident happened. LN 1 stated that Resident 1's assigned nurse .was in the area coming and asked for gauze, so I went to get what the nurse needed . that was all. An interview was conducted with LN 2 on 2/6/18 at 11 A.M. LN 2 stated he was the supervisor (charge nurse) on 1/23/18, the morning of the incident. LN 2 stated that when he checked on Resident 1, the nurse was doing an assessment. A review of Resident 1's Neurological Assessment Flow Sheet, dated 1/23/18 was conducted. This record included scheduled neuro checks to be conducted at 11 A.M., 11:15 A.M., 11:30 A.M., 12:30 P.M., 1 P.M., and 2 P.M. There were no signatures in each of the designated areas to reflect the neuro check assessments were performed. The facility's Neurological Assessment Flow Sheet, revised July 2015, included the following instructions: .Document . signature .sign to verify documentation. The facility's Neurological Assessment policy, revised July 2015, indicated .Policy . C. Following a . or other accident/injury involving head trauma . II. Neurological checks (neuro checks) will be performed . IX. Documentation . The following will be documented in the resident's medical record: .ii. The name and title of the individual(s) who performed the procedure . v. The signature and title of the person recording the data . A concurrent interview and review of Resident 1's Neurological Assessment Flow Sheet dated 1/23 through 1/25/18 was conducted with the director of nursing (DON) on 2/6/18 at 11:20 A.M. The DON stated, because Resident 1 had a head trauma injury, staff performed neuro checks. The DON stated the neuro checks were performed at the scheduled times. The DON could not identify which nurses performed the

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assessments because there were no signatures in the designated areas of the flow sheet. The DON acknowledged that LN signatures were not consistently signed in the designated areas of Resident 1's Neurological Assessment Flow Sheet, and should have been. 2. A review of Resident 1's record was conducted. A physician order, dated 11/12/17 included a 16 Fr (French; size reference of Foley) Cath (catheter) Insertion for Bone Density (bone scan; test that measures bone strength) Appointment on 11/13/17. Resident 1's progress notes dated November 2017 were reviewed. There was no documentation that a Foley cath had been inserted on 11/12/17 or 11/13/17. The progress note dated 11/13/17 included documentation, DC'd (discontinued; removed) FC (Foley catheter) per MD (physician) orders; FC only in for bone density apt (appointment) today. A physician order, dated 11/13/17 included a rescheduled appointment for Resident 1 to have a bone scan on 11/29/17. A physician order [REDACTED].on 11/29/17. The progress note dated 11/27/17 included documentation, New order to insert foley catheter 16 French tomorrow 11/28/17 in evening for procedure on Wednesday. Further review of Resident 1's progress notes dated November 2017, there was no documentation that a FC had been inserted on the evening of 11/28/17 or on 11/29/17. A progress note dated 11/30/17 indicated that Resident 1 returned from appointment ., but did not specify if it was a bone scan appointment. In addition, there was no documentation that indicated if a FC had been inserted or removed before or after this appointment. In an interview with the director of nursing (DON) on 4/10/18 at 3:15 P.M., the DON stated there was no documentation in Resident 1's record, that a FC was inserted for the bone scan that was scheduled on 11/13/17. The DON further stated she did not know what day the FC was discontinued (removed) after the rescheduled bone scan appointment, since it was not documented. The DON acknowledged Resident 1's record did not include complete and accurate documentation of when Resident 1's FC was inserted and removed.