STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055286	A. BUILDING _____ B. WING _____	04/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KEARNY MESA CONVALESCENT AND NURSING HOME	7675 FAMILY CIRCLE DRIVE SAN DIEGO, CA 92111

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create new care plans and follow an existing care plan for one of two sampled residents (1) when: 1. A care plan was not created for Resident 1 after a fall occurred on 3/7/19; 2. A care plan was not created for Resident 1 to address a physicians order for the use of [REDACTED]. These failures presented a risk of staff to not have the knowledge of Resident 1's care needs, and placed the resident at risk for injury. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The clinical record for Resident 1 was reviewed on 6/12/19. 1. The Fall Incident COC (change of condition) Assessment completed on 3/7/19 indicated Resident 1 had a fall on 3/7/19 at 8 A.M. During a concurrent interview and record review on 7/31/19 at 2:05 P.M., with the Director of Nursing (DON), DON 1 stated there had been no short term care plan done for Resident 1's fall on 3/7/19. DON 1 stated, Typically a care plan is done for each fall. I have no answer for why a care plan was not done. 2. A Physicians Orders, dated 2/28/19, indicated Landing pad when patient is in bed for fall precaution every shift. During a concurrent interview and record review on 6/13/19 at 10:35 A.M., with DON 1, DON 1 stated landing mats (pads) were not added to the Care Plan for Resident 1. DON 1 stated, Yes it should have been care planned. Per the facility's policy titled Develop-Implement Comprehensive Care Plans, dated 2017, .The facility develops a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs . 3. A review of the Physicians Orders, dated 6/1/19 - 6/10/19, indicated an order was written on 4/9/19 for [MEDICATION NAME] (commonly used to treat high blood pressure) to be given unless the systolic blood pressure (SBP-top number) was less than 110 and another order written on 3/26/19 indicated [MEDICATION NAME] (used to increase SBP)was to be administered if SBP fell below 90. A review of the Medication Record, dated 5/1/19 - 5/31/19, indicated [MEDICATION NAME] was administered four times in the month of May when Resident 1's SBP was documented to be less than 110 and, per the physician's orders [REDACTED]. Additionally, [MEDICATION NAME] was not administered as it should have been two times during the month, on 5/5/19 when the SBP was 87, and again on 5/7/19 when the SBP was 88. During a telephone interview on 3/27/20 at 11 A.M., with LN 4, LN 4 stated she could see on the May 2019 Medication Record that she charted that she gave [MEDICATION NAME] on two occasions. LN 4 stated she administered the medication on 5/24/19 when Resident 1's SBP, and again on 5/27/19 when the residents SBP was 92. LN 4 confirmed the order stated to hold the medication if the SBP was below 110, and confirmed it should not have been given. During a telephone interview on 3/27/20 at 11:10 A.M., with DON 2, DON 2 confirmed [MEDICATION NAME] had been given to Resident 1 a total of four times during the month of May 2019, when it should have been held. DON 2 confirmed [MEDICATION NAME] had not been administered on 5/5/19 when the SBP was 87, and again on 5/12/19 when the SBP was 82, but it should have. DON 2 stated low blood pressure could cause dizziness.
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 interview and record review, the facility failed to ensure one of two sampled residents (1) had adequate functionality and availability of assistive devices when Resident 1 fell from his bed without: 1. A physician ordered bed alarm sounding; and, 2. A physicians ordered landing mat in place. This failure had the potential to cause serious injury to Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The clinical record for Resident 1 was reviewed on 6/12/19. 1. A review of the physician order, dated 2/28/29, indicated Bed alarm on for safety, check function and placement every shift. Nursing Progress Notes, dated 6/10/19 at 4:04 A.M., indicated on 6/10/19 at 3:20 A.M., Resident 1's roommate went to the nurses station to inform the staff that Resident 1 was on the floor. Staff responded and found Resident 1 on the floor. The Minimum Data Set (MDS - a standardized assessment and care planning tool), dated 3/26/19, indicated Resident 1 did not walk without extensive assistance. This same MDS also indicated Resident 1 had two previous falls since admitted to the facility on [DATE]. During an interview on 6/12/19 at 4:25 P.M., with Certified Nursing Assistant (CNA) 1, CNA 1 stated we all rushed into the room when the roommate told us Resident 1 was on the ground. CNA 1 stated, I didn't hear the alarm. During an interview on 6/13/19 at 6 A.M., with LN 3, LN 3 stated he was the nurse assigned to Resident 1 and rushed into the room along with CNA 1. LN 3 stated Resident 1 had an order for [REDACTED]. LN 3 stated he did not check the functionality of the bed alarm at anytime during his shift that started at 11 P.M. (four hours and 20 minutes prior to the Resident 1's fall). During a telephone interview on 6/13/19 at 10:55 A.M., with LN 5, LN 5 stated he worked a short shift from 2:30 P.M. to 7:30 P.M., on the evening of 6/9/19 to help train a newer nurse (LN 1) on the P.M. shift (3 to 11 P.M.). LN 5 stated she believed Resident 1 had an order for [REDACTED].M., with LN 1, LN 1 stated he worked the P.M. shift of 6/9/19 taking care of Resident 1. LN 1 stated he and LN 5 put Resident 1 to bed around 7 P.M. LN 1 stated he did not remember if Resident 1 had an order for [REDACTED].M., with the Director of Nursing (DON) 1, DON 1 confirmed Resident 1 had a continuous bed alarm order in place since 2/28/19. During an interview on 3/26/20 at 1:40 P.M., with the Director of Staff Development (DSD), the DSD stated he taught in-service training's to check bed alarms at the beginning of the shift. 2. A review of the physicians order, dated 2/28/29, indicated Landing pad (mat) when patient is in bed for fall precaution every shift. During an interview on 6/12/19 at 4:25 P.M., with CNA 1, CNA 1 stated, I don't remember seeing any mats. CNA 1 stated she did not know if Resident 1 had an order for [REDACTED]., with LN 3, LN 3 stated he was the nurse assigned to Resident 1 and rushed into the room along with CNA 1. LN 3 stated Resident 1 had an order for [REDACTED].M., with LN 5, LN 5 stated he worked a short shift from 2:30 P.M. to 7:30 P.M., on the evening on 6/9/19 to help train a newer nurse on the P.M. shift (3 to 11 P.M.). LN 5 stated he did not know whether Resident 1 had an order for [REDACTED].Implements interventions, including adequate supervision and/or assistive devices, to reduce the risks on an accident .Monitors the effectiveness of the interventions .
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 medical records were complete and accurately documented for one of two sampled residents (1), when: 1. An Interdisciplinary Team (IDT) note generated from discussion of Resident 1's fall on 5/22/19 was not documented in the residents medical record until 6/10/19, 2. No documentation was made in

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) Interdisciplinary Progress Notes by the licensed nurse that investigated the fall on 5/22/19; and, 3. A licensed nurse documented a bed alarm was checked for functionality for Resident 1 when the check had not been completed. These failures presented a risk that staff who cared for Resident 1 may not have known the resident's true medical condition, thereby potentially causing changes in condition to not be promptly and properly acted upon. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The clinical record for Resident 1 was reviewed on 6/12/19. 1. The Fall Incident COC (change of condition) Assessment, dated 5/22/19, indicated Resident 1 had a fall on 5/22/19. No records could be found of an IDT meeting to discuss the fall until 6/10/19. During an interview on 8/5/19 at 1:40 P.M. with the Director of Nursing (DON) 1, DON 1 stated the IDT note for the fall on 5/22/19 was not charted in Resident 1's medical record until 6/10/19. DON 1 stated, I forgot to close it on the day I was supposed to. 2. A review of Interdisciplinary Progress Notes indicated no documentation was made by nursing staff related to Resident 1's fall on 5/22/19. During a telephone interview on 8/5/19 at 3 P.M., with Licensed Nurse (LN) 2, LN 2 stated, I usually do progress notes about a fall but I guess I didn't on that one. During a telephone interview on 3/27/20 at 11:10 A.M., with DON 2, DON 2 confirmed Resident 1's fall on 5/22/19 was not documented in the progress notes as it should have been. Per the facility's policy, titled Generations Falls Management, dated 2015, .The Licensed nurse will document in the nurse notes the time, date, and location of the fall and notify physician and family .The Interdisciplinary Care Plan team will complete a review .This will be completed within 72 hours . Per the facility's policy, titled Documentation Policy, dated 2016, .staff members are only to chart what they see and hear related to a resident . 3. A review of the Physicians Orders, dated 6/1/19 - 6/10/19, indicated an order was written on 2/28/19 Bed alarm on for safety, check function and placement every shift. Per Resident 1's Medication Record, dated 6/1/19 - 6/30/19, the alarm was documented by LN 1 that it had been checked on 6/9/19 for the 5 P.M. to 11 P.M. shift. The Nursing Notes, dated 6/10/19 at 4:04 A.M., indicated nursing became aware that Resident 1 had fallen when Resident 1's roommate came to the nurses station at 3:20 A.M. and notified staff Resident 1 was on the floor. During a telephone interview on 6/13/19 at 6 A.M., with LN 3, LN 3 stated he was the nurse for Resident 1 on the 11 P.M. to 7 A.M. shift for the night of 6/9/19 through the morning of 6/10/19. LN 3 stated he rushed into Resident 1's room when his roommate came to the nurses station and told him Resident 1 was on the floor. LN 3 stated the bed alarm did not go off like it was supposed to. During an interview on 6/13/19 at 11:40 A.M., with LN 1, LN 1 stated that he was the nurse for Resident 1 on the 5 P.M. to 11 P.M. shift of 6/9/19. LN 1 stated I don't remember if he (Resident 1) had an order for [REDACTED]. LN 1 stated he did not know why he charted that he had checked the bed alarm. Per the facility's policy, titled Falls Prevention-Potential Safety Interventions, dated June 2016, .Monitors the effectiveness of the interventions .