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 _____	**05/27/2020**

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 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 care plan related to falls for one of three sampled residents (1) with a history of falls. This failure had the potential to increase the risk of falls and injury for Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. There was no opportunity for an observation of Resident 1, as he had been transferred to another facility. A review of Resident 1's medical record was conducted on 10/28/19 at 1:09 P.M., and indicated the following: 1. A Fall Risk Assessment, dated, 9/13/19, indicated a score of 19, category: high risk. 2. The Interdisciplinary team (IDT) assessment and restraint consent, dated, 9/13/19, indicated: team recommendations based on assessment: bed alarm. 3. The initial care plan, dated, 10/17/19, titled, the Resident (1) is at high risk for falls, does not include the use of a bed alarm. 4. A nursing progress note, dated 9/23/19, indicated, .resident had a fall 9/23/19, sent out to (name of hospital) for eval . A concurrent interview and record review was conducted with the director of nursing (DON) and assistant director of nursing (ADON) on 10/28/19 at 2:17 P.M. The DON stated the use of the bed alarm was not in the initial care plan. The DON stated, The initial care plan should have had additional interventions since the resident (1) was a high fall risk. A review of the facility's policy, dated 10/14/15, titled, Generations Falls Management, indicated, . Purpose: the purpose of the Falls Management Program is to .2. initiated preventive approaches, 3. provide appropriate strategies and interventions directed to residents, environmental factors and staff .

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.