STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	**510 E. WASHINGTON AVENUE EL CAJON, CA 92020**

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 0573 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medical record copies within two working days of the request for one of two sampled residents (2). As a result, Resident 2's RP (Responsible Party) did not receive a copy of Resident 2's medical records for more than six working days. Findings: Per the facility's Resident Face Sheet, Resident 1 was admitted to the facility on [DATE] and expired on [DATE]. On [DATE] at 10 A.M., an interview was conducted with the MRD (Medical Records Director). The MRD stated, Resident 2's RP requested medical records on [DATE]. The MRD further stated, she had not provided Resident 2's medical records, but planned to do so within 15 days of the request. Per the MRD's forwarded email, Resident 2's RP requested medical records from the MRD on [DATE], and on [DATE] the MRD emailed Resident 2's conservator to request permission to release medical records to the responsible party. Per the facility's General Record Release Log, dated [DATE]-[DATE], Resident 2's RP requested 52 pages of documents on ,[DATE], which was not accurate to the date of the email request of [DATE], and the documents were mailed out on ,[DATE]. On [DATE] at 11:20 A.M., a telephone interview was conducted with the MRD. The MRD stated, Resident 2's RP made the medical records request on [DATE], and the facility received permission from Resident 2's conservator to release the medical records on [DATE]. The MRD further stated, she should have documented ,[DATE] as the date Resident 2's RP requested records on the General Record Release Log. Per the facility's Policy, titled Release of Information, revised [DATE], .10. A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request .
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 follow a physician's order for one of three residents (1). As a result, Resident 1's blood sugar level was unknown on the day of admission. Findings: Per the facility's Resident Face Sheet, Resident 1 was admitted to the facility on [DATE] at 7:30 P.M., with [DIAGNOSES REDACTED]. Per the facility's Medications Flowsheet, dated 2/1/18 through 2/28/18, there was an order to check Resident 1's blood sugar at 9 P.M. There was no blood sugar recorded for 9 P.M. on the day of admission. Per the facility's Resident Progress Notes, dated 2/22/18, there were no notes to indicate the facility checked Resident 1's blood sugar on the day of admission. On 5/14/19 at 10:40 A.M., a concurrent interview and record review was conducted with the MRA (medical records associate). The MRA stated, the Medications Flowsheet (a record to document medication administration and checks) for Resident 1 did not have any entries for blood sugar on 2/22/18. The MRA further stated, the Medications Flowsheet was the only place for staff to record blood sugar checks. On 5/14/19 at 11:15 A.M., an interview was conducted with LN (Licensed Nurse) 1. LN 1 stated, if a resident needed a blood sugar check, but the LN had not yet entered the order onto the Medications Flowsheet, then the nurse should have checked the blood sugar and documented the blood sugar results in the nursing notes. On 5/14/19 at 11:40 A.M., an interview was conducted with the DON (Director of Nursing). The DON stated LN 2 was the nurse that admitted Resident 1 on 2/22/18 at 7:30 P.M., and LN 2 was responsible for entering the blood sugar order. The DON further stated, the order was entered at 11:14 P.M., which was late, and the blood sugar should have been checked at 9 P.M. LN 2 was unavailable for interview. The facility's policy, titled Fingerstick Glucose Level, revised October 2014, did not address the timing of checking a resident's blood sugar.

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.