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 _____	09/28/2020

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow nursing standards of practice related to communicating abnormal lab values to the next shift for one of three residents (Resident 1) reviewed for quality of care. This failure resulted in Resident 1 being hospitalized with [MEDICAL CONDITION] (a high concentration of sodium in the blood) and dehydration (a loss of water from the body). Findings: Resident 1 was re-admitted to the facility on [DATE], with diagnoses, which included dysphagia (difficulty swallowing), and [MEDICAL CONDITION] (a disease that affects the function of the brain), per the facility's Admission Record. On 3/6/20, Resident 1's clinical record was reviewed: According to the physician's History and Physical, dated 7/2/19, Resident 1 did not have the capability to understand and make decisions. According to Resident 1's physician's orders [REDACTED].Flush GT (gastrostomy tube: a surgical tube inserted into the stomach to deliver nutrition and fluids) feeding with 60 ml (milliliter) of H2O (water) before feeding and 60 ml after feeding 2 times a day .Water flush of 250 ml every 4 hours for total of 1500 ml per 24 hours every 4 hours for hydration. The nursing notes, dated 2/14/20 for the shift of 7 A.M. to 3 P.M. indicated, Resident 1's [DEVICE] was accidentally pulled out. According to Resident 1's physician's orders [REDACTED].M., Start hydration IV (intravenous-administration of fluid into a vein) .BMP (laboratory test-basic metabolism panel) x 3 days (once daily) .Schedule KUB (abdominal) x-ray for GT placement. According to nurses notes, dated 2/14/20 from 6 P.M. through 2/15/20 at 9 P.M., .numerous attempts to start intravenous fluids were unsuccessful, M.D. (Medical Doctor) notified. Resident 1's physician's orders [REDACTED].M., Discontinue IV hydration and BMP x3. Resident 1's Laboratory Report's were reviewed: On 2/14/20, Resident 1 had a sodium level of 157 mEq/L (milliequivalents per litre), (normal reference range listed as 135-145). Chloride level 114 mEq/L (normal 90-109). Licensed Nurse (LN 6) documented on the laboratory report Faxed to MD 2/15/20 1:17 A.M. On 2/15/20, Resident 1 had a sodium level of 160 mEq/L. Chloride level 115 mEq/L. LN 8 documented on the laboratory report Faxed to M.D. 2/15/20 9:40 P.M. Unit Five's 24 hour Report/Charting of Condition Reports were reviewed: On 2/14/20, Resident 1 was listed on the report: 1. The shift for 11 P.M. to 7 A.M., had no entry. 2. The shift for 7 A.M. to 3 P.M., indicated, GT pulled out. 3. The shift for 3 P.M. to 11 P.M., indicated that Resident 1's GT re-insertion was scheduled for 2/18/20. On 2/15/20, Resident 1 was listed on the report: 1. The shift for 11 P.M. to 7 A.M., indicated, Radiology tech to be here 5 A.M.-7 A.M. 2. The shift for 7 A.M. to 3 P.M., indicated, BMP done. 3. The shift for 3 P.M. to 11 P.M., indicated, needs IV hydration. On 2/16/20, Resident 1 was listed on the report: 1. The shift for 11 P.M. to 7 A.M., had no entry. 2. The shift for 7 A.M. to 3 P.M., indicated GT intact/patent. 3. The shift for 3 P.M. to 11 P.M., had no entry. On 3/6/20 at 10:58 A.M., an interview was conducted with LN 9. LN 9 stated if laboratory results were abnormal, the laboratory called the nurses and also faxed a copy of the results. The nurses then informed the physician and documented the abnormality in the 24-hour charting, so all staff could be aware of what was going on with the resident. LN 9 stated the 24-hour charting record was important to nursing staff as a means of communication and documentation, so all were informed. LN 9 reviewed the 24 hours charting notes for Resident 1 from 2/14/20 through 2/16/20. LN 9 stated the abnormal laboratory results were not documented and they should have been. On 3/6/20 at 12:04 P.M., an interview was conducted with LN 10. LN 10 stated the signs of dehydration include low blood pressure, possible fever, dry mucous membranes and poor skin turgor (elasticity-the ability of the skin to shape and return to normal). LN 10 stated lab analysis that could indicate dehydration included, sodium, potassium, chloride, and kidney function-such as BUN (blood urea nitrogen) and creatinine. LN 10 stated if the labs were unusually high or low, they should be listed in the 24-hour charting report. On 3/11/20 at 2:44 P.M., an interview and record review was conducted with the Registered Dietician (RD). The RD stated on 2/28/20 she was reviewing Resident 1's tube feeding and noticed two previous abnormal laboratory results. The RD stated she could not find any evidence the abnormal lab results were addressed or followed up on. The RD stated she ordered a CMP (comprehensive metabolic panel) and a CBC (complete blood count), to learn what Resident 1's current electrolytes were. The RD stated Resident 1's labs were not drawn over the weekend because they were not ordered STAT (immediate). The RD stated Resident 1 was admitted to the hospital on [DATE], so the follow-up labs were not drawn. The RD stated Resident 1's labs could indicate dehydration at the time, and that was why she ordered labs again one week later to see what his current status was. A review of Resident 1's Hospital ED (Emergency Department) Note, listed the admitting diagnoses, which included severe dehydration, critical [MEDICAL CONDITION], (high sodium level), critical hyperchloremia (high chloride level). Resident 1's sodium level on ED admission was 172 mEq/L and chloride was 134 mEq/L. On 3/11/20 at 11:39 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1's abnormal labs results were not followed through and all nurses were responsible to make sure the abnormal labs were being addressed. The DON stated Resident 1's laboratory results should have been documented in the 24-hour charting, so all staff were aware of the resident's status. The DON stated just faxing the orders to the M.D. does not guarantee they were reviewed and staff should have called the physician the following morning. The DON stated a complete follow through should have been done. On 3/13/20 at 8:30 A.M., an interview was conducted with the Medical Doctor (MD). The MD stated he did not recall being notified of any elevated sodium levels for Resident 1. The MD stated he would have wanted to know if anything was abnormal, so he could address it immediately. On 9/12/20 at 7:07 A.M., an interview was conducted with LN 6. LN 6 stated she worked the night shift and was responsible for starting the 24-hour charting for the next shift. LN 6 stated the 24-hour charting was an important means of communication, so all LNs knew what was important for their shift, such as what was needed or what needed to be followed up on. LN 6 stated abnormal lab results should be listed on the 24-hour charting. LN 6 stated a normal sodium level was 140. LN 6 verified she received Resident 1's lab results on 2/14/20 and faxed the results to the physician. LN 6 stated she did not list the abnormal sodium level on the 24-hour charting and she should have. LN 8 was unavailable for an interview. According to the facility's policy, titled Change in a Resident's Condition or Status, dated May 2017, .2. A significant change of condition is a major decline .a. Will not resolve itself without intervention by staff .d. Ultimately is based on the judgement of the clinical staff . According to the facility's policy, titled Lab and Diagnostic Test Results-Clinical Protocol, dated November 2018, .3. A nurse will identify the urgency of communicating with the Attending Physician .the seriousness and any abnormality . Physician Responses: 1. A physician will respond within an appropriate time frame .b. If the Attending or Covering Physician does not respond .the nursing staff should contact the Medical Director for assistance .
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**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on interview and record review, the facility failed to accurately document enteral feedings (a liquid form of nourishment that is delivered to your body through a flexible tube) and fluid administration for one of three residents (Resident 1), reviewed for gastrostomy tube ([DEVICE]: a surgical tube inserted into the stomach) care. As a result, Resident 1's clinical record did not reflect an accurate depiction of the residents current status when staff documented the resident's enteral feeding and hydration fluids were being provided when the [DEVICE] had been accidentally removed and had not yet been replaced. Findings: Resident 1 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/6/20, Resident 1's clinical record was reviewed: According to the physician's History and Physical, dated 7/2/19, Resident 1 did not have the capability to understand and make decisions. According to Resident 1's physician's orders [REDACTED].[MEDICATION NAME] (a caloric nutritional formula) was to be provided via [DEVICE] at 65 cubic centimeters (cc) per hour for 20 hours .water flush every four hours for hydration providing, 1500 milliliters of fluids every 24 hours . Resident 1's nursing notes, dated 2/14/20, for the 7-3 P.M. shift, documented Resident 1's [DEVICE] was accidentally pulled out. Resident 1's physician's orders [REDACTED].M., instructed staff to restart [DEVICE] feedings after [DEVICE] was re-inserted. Resident 1's medication administration record (MAR) for February 2020 was reviewed. The MAR documented [MEDICATION NAME] feeding was initiated for a 20-hour period, starting on 2/14/20 at 5 P.M. after the [DEVICE] had been documented as accidentally pulled out. The MAR was initialed by Licensed Nurse (LN 7) on 2/14/20 at 4 P.M., 8 P.M., and again by LN 6 on 2/15/29 at midnight and 4 A.M., that 250 cc hydration flushes were administered via [DEVICE]. The MAR was initialed the [DEVICE] placement had been checked on the evening and night shift of 2/14/20 and the [DEVICE] residual (the volume of fluid remaining in the stomach, which is withdrawn by use of a syringe) was 0 when aspirated. LN 7 was unavailable for an interview. On 3/11/20 at 10:58 A.M., an interview and record review was conducted with LN 5. LN 5 stated Resident 1's [DEVICE] accidentally came out on 2/14/20. A specialized physician came to the facility on the evening of 2/15/20 and re-inserted the tube. LN 5 stated while the [DEVICE] was out, Resident 1 had not received any nutrition or fluids. LN 5 reviewed Resident 1's MAR and stated the charting was inaccurate. LN 5 stated Resident 1 did not receive feeding or hydration on the evening of 2/14/20 or the early morning of 2/15/20, as indicated on the MAR because Resident 1's [DEVICE] had not been reinserted yet. LN 5 stated the inaccurate charting by the LN's gave a false picture of Resident 1's current condition. LN 5 stated the inaccurate documentation indicated the LN's were completely unaware of what was going on with Resident 1. On 3/11/20 at 11:39 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1's MAR was inaccurate if the LN's were documenting formula and fluids were being administered via the [DEVICE], when in fact the [DEVICE] had been accidentally pulled out. On 3/11/20 at 2 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated the LNs were constantly trained to document accurately. The DSD stated if staff documented Resident 1's feeding had been administered during the time the [DEVICE] had been removed, then they had not assessed and documented accurately. On 9/12/20 at 7:07 A.M., a telephonic interview was conducted with LN 6. LN 6 stated if a MAR task was not performed, the LN would initial and circle the entry, making a note on the back of the MAR, for why the task was not completed. LN 6 stated she later learned from the DON of her inaccurate documentation for Resident 1 regarding his [DEVICE]. LN 6 stated for 2/15/20, her charting was inaccurate because Resident 1's [DEVICE] was not in place and there was no way she could have administered fluids or nutrition. According to the facility's policy, titled Charting and Documentation, dated July 2017, All services provided to the resident .should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .