

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2024
NAME OF PROVIDER OR SUPPLIER  Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7800 Parkway Drive LA Mesa, CA 91942	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38512</p> <p>Based on interview and record review, the facility failed to clarify a physician ' s order for a medication for one of two residents reviewed for plan of care (Resident 1).</p> <p>This failure resulted in Resident 1 not receiving the medication for 12 days, with the potential for blood clots or other complications.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses to include atherosclerosis of coronary artery bypass graft (a build-up of plaque in the arteries of the heart, which can cause blockage, or heart attack), per the facility Admission Record.</p> <p>On 8/12/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). Per the DON, Resident 1 went out of the facility to many types of doctor appointments. The DON stated the process for communicating with the doctors was for the doctor to write any prescriptions or progress notes to send back from their office to the facility. The facility Licensed Nurse (LN) who received the orders should document the order in the Transportation Log book for the date received, then the following business day, the charge nurse would review and follow up on the new order.</p> <p>On 8/12/24 at 3:55 P.M., a concurrent interview and record review was conducted with the DON.</p> <p>The DON reviewed the Transportation Log book entry for 719/24. A note was written at the bottom of the page, indicating to follow up with Neurologist (a doctor who specialized in the brain) if Resident 1 needed a blood thinner for an appointment for a computerized tomography scan (CT, a specialized x-ray). The note was not signed and did not indicate the time it was written. The DON identified LN 1 as the author of the note.</p> <p>Resident 1 ' s physician ' s orders indicated Resident 1 received the first dose of the blood thinner on 7/31/24, 12 days after the transportation log note was written.</p> <p>During record review, no progress note was found regarding discussion with the neurologist.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated the request to call the neurologist should have been discussed during Stand Up (a team meeting) on 7/22/24. Per the DON, the charge nurse would be responsible for leading the discussion and following up with the physician on the blood thinner. The DON stated she would expect a progress note from the charge nurse with the final disposition of the medication. Per the DON, waiting three days for a medication to be discussed was too long, and could prevent the resident from receiving a medication the physician wanted him to have.</p> <p>On 8/12/24 at 4:30 P.M., an interview was conducted with LN 1. LN 1 stated she had written the note regarding the blood thinner on the Transportation Log. LN 1 stated the note would have been discussed the following Monday, three days later, during Stand Up. LN 1 stated the LN who followed up would then write a progress note with the physician ' s decision about the blood thinner.</p> <p>On 8/13/24 at 10:35 A.M., an interview was conducted with LN 2. LN 2 stated she was the charge nurse on Monday 7/22/24. LN 2 stated she did not recall whether the blood thinner for Resident 1 was discussed during the Stand Up meeting. LN 2 stated the facility process was to write requests on the transportation log, then discuss at the next Stand Up meeting, and then document the discussion on a progress note. LN 2 stated she was unable to find a progress note regarding the blood thinner. Per LN 2, waiting three days between the request for a call to the neurologist and an actual call was too long. LN 2 stated Resident 1 did not receive the blood thinner until 12 days after the request to clarify with the neurologist. Per LN 2, not having the blood thinner could have caused Resident 1 to have a blood clot, stroke, or other complication.</p> <p>The facility was unable to provide a policy regarding following physician ' s orders for medications.</p>		