

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Kearny Mesa Convalescent and Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466</p> <p>Based on interview and record review the facility failed to provide supervision for one of two residents (Resident 1) when Resident 2's wandering (moving from place to place) behavior was not identified which resulted to an altercation with Resident 1.</p> <p>This failure had the potential for Resident 1's safety and wellbeing.</p> <p>Findings:</p> <p>Review of Resident 1's Admission Record indicated, Resident 1 was admitted on [DATE] to the facility with diagnoses that included Chronic Pain Syndrome, and dependent on wheelchair use.</p> <p>A review of Resident 2's Admission Record indicated, Resident 2 was admitted on [DATE] to the facility with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory), and Dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>An interview on 5/28/24 at 10:30 A.M., with Resident 1 was conducted. Resident 1 stated Resident 1 was sitting on her wheelchair in her room when Resident 2 came from behind. Resident 1 stated she told Resident 2 to get out of the room and Resident 2 suddenly hit Resident 1 at the back of her head and felt pain and told staff. Resident 1 stated staff immediately separated her from Resident 2 and notified the licensed nurses.</p> <p>A record review of Resident 1's Minimum Data Set (MDS-assessment tool) indicated a BIMS (brief interview for mental status) score of 14 which indicated Resident 1's cognition was intact. BIMS score of 0-7 indicated severe cognitive impairment, 8-12 indicated moderate cognitive impairment, and a score of 13-15 indicated cognition was intact.</p> <p>A record review of Resident 2's MDS dated [DATE] indicated Resident 2's BIMS score was 8, which indicated Resident 2's cognition was severely impairment. The same MDS assessment section E for behaviors, indicated, Resident 2 had wandering episodes and behaviors such as resistance to care.</p> <p>An interview on 5/28/24 at 10:50 A.M., with licensed nurse (LN) 1 was conducted. LN 1 stated resident 2 was ambulatory (able to walk about) and wandered into other resident rooms. LN 1 stated they tried to closely monitor Resident 2 but sometimes it's not feasible.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 5/28/24 at 11:40 A.M., with the Assistant Director of Nursing (ADON) was conducted. The ADON stated it was the first incident between Resident 1 and Resident 2, although Resident 2 had behavioral encounters with other residents in the facility.</p> <p>A phone interview on 5/28/24 at 1:30 P.M., with the Director of Nursing (DON) was conducted. The DON stated Resident 2 has had behaviors of grabbing cookies from other residents and a behavior care plan was initiated instead. The DON stated the facility did not have a wandering assessment for Resident 2 since Resident 2 was not exhibiting exit seeking behaviors on admission.</p> <p>Review of Resident 2's care plan dated, 5/16/24 indicated, behavioral symptoms/problem, pinched another resident's arm, revised 5/20/24.</p> <p>Review of facility's policy titled, Admission Assessment; Role of the Nurse dated September 2012 .#3 conduct supplemental assessments including .f. behavioral assessments.</p> <p>Review of the Centers for Medicare & Medicaid Service of the rights of a nursing home resident included the basic human rights, the right to be free from verbal, sexual, physical and mental abuse .</p>		