STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055286	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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** 47466 Based on observation, interview and record review, the facility failed to perform abdominal assessment and verify Resident 1 ' s appointment prior to sending to Interventional Radiology (IR) clinic. As a result , Resident 1 was left outside of the clinic in a cold weather close to an hour and not needed to be seen at the clinic. Findings: A review of Resident 1 ' s Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included Hydronephrosis with renal and ureteral calculous obstruction(excess fluid in the kidney due to a backup of urine) and Osteomyelitis of the lumbar region (inflammation of the lower back). A review of the hospital record titled, service encounter dated 12/18/24 Hospitalist, History and Physical indicated, in October 2024, Resident 1 had a rising white blood count and had an interloop (to loop together) collection that underwent an IR drainage after which the catheter was removed on November 22, 2024. During an interview on 12/23/24 at 10:26 A.M., with family member (FM) 1, FM 1 stated Resident 1 had an appointment on 12/11/24 for a drain site check at the IR hospital and did not need to be seen at the clinic anymore. FM 1 stated, Resident 1 was left out in the cold weather close to an hour and that FM 1 had to pay for Resident 1 ' s transport to the clinic. An interview on 12/23/24 at 12 noon with Licensed nurse (LN)1 was conducted. LN 1 stated she knew Resident 1 did not have a drain site anymore but was sent to IR at the hospital without verifying the appointment. An interview on 12/23/24 at 2 P.M., with the Unit clerk (UC) was conducted. The UC stated, the admission LN placed the standing orders that came with the resident from the hospital. The UC stated after the LN verified the orders, schedule the appointment, the UC would arrange the transportation and inform the resident ' s family regarding the appointment including the payment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/24/24 at 2:46 P.M., with LN 2 was conducted. LN 2 stated, when a resident got admitted to the facility, the licensed nurse follows the physician orders including appointments from the hospital after verifying with the resident's physician. LN 2 stated the UC was responsible to follow up resident's appointment, scheduling of appointment, and transportation arrangements. An interview on 12/30/24 at 12:31 P.M., with the Director of Nursing (DON) was conducted. The DON stated the admission nurse review and carry over the appointment and the hospital orders. The DON stated FM 1 was upset because she had to pay the transportation for Resident 1 that did not happen because there was no appointment. An interview on 1/13/25 at 8:12 A.M., with LN 3 was conducted. LN 3 stated her role included, admissions and medication administration to residents, initial admission assessments and verification of orders, and scheduling of appointments. Resident 1 had an appointment to follow up with IR for a drain site check on 12/11/24 at 2 P.M. LN 3 stated she handed a copy of the order to the UC to follow up with the clinic and to arrange transportation. LN 3 stated she did not verify with the IR clinic regarding Resident 1 ' s appointment. An interview on 1/17/25 at 3:59 P.M, with the certified nursing assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was dependent with his activities of daily living that included feeding , dressing, and toileting. CNA 1 stated he was not sure if Resident 1 had a device of any sort. A record review of Resident 1 ' s minimum date set (MDS- a federally mandated assessment tool) dated 12/1/24 indicated, Resident 1 ' s brief interview for mental status (BIMS) was 10 which meant Resident 1 had moderate cognition impairment. A review of Resident 1 ' s MDS section GG dated, 12/1/24 indicated, Resident 1 was dependent with his activities of daily living and no attempt was made for Resident 1 to do sit to stand , chair to chair transfer due to medical condition and safety concerns. A review of the weekly summary report dated, 12/07/24 indicated, Resident 1 drain removal site to left lower quadrant with 100% scab, dry and was not being treated. A review of the care plan initiated on 12/7/24 indicated, Resident 1 was admitted with actual impairment to skin integrity with a drain removal site to left lower quadrant (LLQ) of abdomen 0.5 cm x 0.7 cm , 100% scab, dry- arrived back to facility resolved on 12/7/24. A review of the Physicians orders, dated 12/7/24, did not indicate an order for monitoring of the drain site. A review of the facility's undated policy titled, Resident Assessments indicated, assessments are completed by the staff members who have the skills and qualification to assess relevant care areas and who are knowlegeable about the resident's health .