

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER University Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 University Ave San Diego, CA 92105	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471</p> <p>Based on an interview and record review, the facility failed to ensure that pressure injuries (also known as pressure ulcers or bed sores, which are areas of skin and tissue damage caused by prolonged or intense pressure) were documented in the medical record every week per the facility's policy for one of three sampled residents (Resident 1).</p> <p>As a result, Resident 1's progression or deterioration of the pressure injury could not be accurately assessed.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), per the facility's Admission Record.</p> <p>A review of Resident 1's medical record was conducted. Per the Progress Notes dated 3/22/24, Licensed Nurse (LN) 1 documented that Resident 1 had a stage 1 (no skin break) pressure injury to the sacral (tailbone) area and was red.</p> <p>Per the undated Plan of Care, under Focus (Problem Area), Resident 1 had impaired skin integrity related to a stage 1 reddened sacral area. One intervention was to follow the facility protocols.</p> <p>On 6/11/24 at 3:06 P.M., the Treatment Nurse (TN) was interviewed. The TN stated that the protocol for a resident with a wound, such as a stage 1 pressure ulcer, was for them to do the wound assessment every week. TN stated that Resident 1 had a stage 1 pressure ulcer on admission, and there should have been a weekly wound assessment, but it was missed.</p> <p>LN 1 was not available for an interview.</p> <p>On 6/11/24 at 4 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that pressure injuries should be monitor weekly and documented in medical records.</p> <p>Per the facility's policy and procedure, dated 2001, titled Pressure Injury Risk Assessment, .Repeat the skin assessment weekly .</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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy and procedure, dated 2001, titled Pressure Injuries/Skin Breakdown - Clinical Protocol, .If a skin issue is noted the nurse should describe and document/report the following: Anatomical location stage, size .skin surrounding the ulcer .		