STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055910	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER: Country Manor LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5696 Lake Murray Blvd, 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)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on record review and interview, the facility failed to notify one (Resident 8) of four resident ' s representative reviewed for resident rights when: 1. The resident ' s representative was not notified of new orders for lab and a medication, 2. The resident ' s representative was not notified of a new order for insulin, 3. The resident ' s representative was not notified that the insulin was not administered according to the Nurse Practitioner ' s (NP-a registered nurse with advanced training and education qualified to treat certain medical condition without the direct supervision of a doctor) order, 4. The resident ' s representative was not notified of the NP ' s order for a medication. This failure resulted in the resident ' s representative to not be informed of Resident 8 ' s condition and the plan of care. Findings: Resident 8 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus (too much sugar circulating in the blood) according to the facility ' s Admission Record. The Admission Record further indicated Resident 8 ' s daughter as POA [power of attorney- a legal document that allows someone to act on their behalf]- Care Emergency Contact #1. 1. A concurrent record review and interview was conducted on 12/18/24 at 9:57 A.M. with licensed nurse (LN) 3 at the facility ' s conference room. LN 3 reviewed progress notes for Resident 8. LN 3 stated Resident 8 ' s lab results were reported to the NP and new orders for lab and a medication was received. LN 3 stated there was no documentation that Resident 8 ' s daughter was notified of the new orders. (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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent record review and interview on 12/18/24 at 9:57 A.M. with LN 3, LN 3 stated Resident 8 had a change in condition on 4/29/24 at 6:48 A.M. due to Resident 8 ' s blood sugar of 297. LN 3 stated according to Resident 8 ' s progress notes, a message was left for the physician. LN 3 stated the progress notes indicated at 1:43 P.M. Resident 8 asked a LN if the physician gave orders regarding his elevated blood sugar. LN 3 stated the progress notes indicated the assigned LN followed up with the NP only after Resident 8 asked. LN 3 stated the NP gave orders to check Resident 8 ' s blood sugar every meal and at bedtime; insulin per sliding scale (amount of insulin to be given based on blood sugar result). LN 3 stated the progress notes did not indicate Resident 8 ' s daughter was notified of the change in condition and the new orders. 3. During a concurrent record review and interview on 12/18/24 at 9:57 A.M. with LN 3, LN 3 stated Resident 8 ' s progress notes indicated Humalog (a fast-acting insulin) KwikPen (a disposable pre-filled pen containing insulin) was Not available on 4/29/24 at 5:42 P.M. and on 4/29/24 at 9:31 P.M. LN 3 stated the progress notes indicated the medication was On order, waiting for delivery. LN 3 stated there was no documentation to notify Resident 8 ' s representative that the medication was not administered to Resident 8. 4. During a concurrent record review and interview on 12/18/24 at 9:57 A.M. with LN 3, LN 3 stated Resident 8 ' s progress notes indicated Resident 8 ' s lab results were reported to the NP on 5/3/24 at 2:09 P.M. LN 3 stated the NP gave new orders on 5/3/24 at 2:11 P.M. LN 3 stated the progress notes did not indicate what the new orders were Resident 8 ' s representative were not notified. LN 3 further stated it was important for Resident 8 ' s family or responsible party to know what was going with the resident and the treatment plan according to physician ' s orders. An interview was conducted with the Director of Nursing (DON) on 1/9/25 at 3:16 P.M. DON stated Resident 8 ' s family should have been notified of the new physician ' s orders to be fully aware of the Resident 8 ' s care and to advocate for the resident. A review of the facility ' s policy and procedure (P&P) titled, Resident Rights Guidelines for All Nursing Procedures, dated October 2010 was reviewed. The P&P indicated, .Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including . Resident notification of rights, services, and health/medical condition . During a review of the facility ' s P&P titled, Change in a Resident ' s Condition or Status, dated February 2021, the P&P indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status .

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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** 38924 Based on interview and record review the facility failed to provide a medication for an elevated blood sugar for one of four residents (Resident 8) reviewed for quality of care. This failure had the potential for further decline in Resident 8 ' s medical condition. Findings: Resident 8 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus (too much sugar circulating in the blood) according to the facility ' s Admission Record. A concurrent record review and interview was conducted on 12/18/24 at 9:57 A.M. with licensed nurse (LN) 3 at the facility ' s conference room. LN 3 reviewed progress notes (PN) for Resident 8. LN 3 stated Resident 8 had a change in condition on 4/29/24 at 6:48 A.M. due to Resident 8 ' s blood sugar of 297 and a message was left for the physician. LN 3 stated the PN indicated at 1:43 P.M., Resident 8 asked a LN if the physician gave orders regarding his elevated blood sugar. LN 3 stated the PN indicated the assigned LN followed up with the nurse practitioner (NP) only after Resident 8 asked. LN 3 stated the NP gave orders to check Resident 8 ' s blood sugar every meal and at bedtime; insulin per sliding scale (amount of insulin to be given based on blood sugar result). LN 3 stated there was no follow up documentation to re-check Resident 8 ' s blood sugar. LN 3 stated she expected for the assigned LN to re-check Resident 8 ' s blood sugar and follow up with the physician within an hour or two if he has not called for orders. A review of Resident 8 ' s physician ' s orders for April 2024 was conducted. The physician ' s orders indicated an order date of 4/29/24, 1:35 P.M. The order indicated, Humalog [fast acting insulin] KwikPen [a disposable pre-filled pen containing insulin] Subcutaneous [fatty tissue, just under the skin] Solution Pen-injector .inject as per sliding scale: if 70-130 = 0 units < [less than] 70 call MD .131-180 = 2 units; 181-240 = 4 units; 241- 300 = 6 units; 301 -350 = 8 units; 351 - 400 = 10 units; 401 - 999 = 12 units call MD . before meals and at bedtime for DM [Diabetes Mellitus] . During a concurrent record review and interview on 12/18/24 at 9:57 A.M. with licensed nurse (LN) 3, LN 3 stated the PN for Resident 8 dated 4/29/24 at 5:42 P.M. indicated, HumalOG [sic] KwikPen Subcutaneous . Pen-Injector .Inject as per sliding scale .Medication not available. On order, waiting for delivery LN 3 stated the PN dated 4/29/24 at 9:31 PM indicated, HumalOG [sic] KWIKPen . Medication not available. On order; waiting for delivery . LN 3 stated if the medication was not available, the nurse should have checked the facility ' s emergency kit (E-Kit) and notify Resident 8 ' s attending physician. The Director of Nursing (DON) entered the conference room during the interview with LN 3 and LN 3 asked the DON if there was Humalog in the emergency kit. The DON stated if the medication was not available, the nurse should notify the resident ' s physician. LN 3 checked Resident 8 ' s medication administration record (MAR) for April 2024. LN 3 stated the MAR indicated 10, a blood sugar result of 275 at 4:30 P.M. and 351 at 9 P.M. LN 3 stated 10 meant other, and it was documented in Resident 8 ' s progress notes as medication was not available. LN 3 stated there was no documentation to show that Resident 8 ' s physician or the pharmacy were not notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted with Resident 8 ' s attending physician (MD) on 12/19/24 at 10:22 A.M. The MD stated he was not aware of the facility not having the Humalog KwikPen for Resident 8. The MD stated the facility should have called and notified him or his nurse practitioner first because the facility could have used insulin via a regular syringe. The DON was interviewed on 1/9/25 at 3:16 P.M. DON stated a change in resident ' s condition was endorsed to the next shift and if the physician has not responded, she expected the nurse to call within one hour or two to follow up. The DON stated she expected the nurse to notify the resident ' s physician if a medication was not available so the physician can order an alternate medication that was available for the resident. The facility ' s policy and procedure (P&P) titled, Administering Medications, dated April 2019 was reviewed. The P&P indicated, .Medications are administered in accordance with prescriber orders, including any required time frame . The P&P did not address when a medication was not available.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on interview and record review, the facility failed to promptly notify the registered dietitian (RD) and physician when one of four residents, (Resident 1), with a compromised medical status, consumed less than 50% of his meals for more than three consecutive days, according to facility policy and standards of practice. This failure led to further decline in Resident 1's nutrition and medical status and contributed to the resident's severe unintentional weight loss of 16 pounds (7.83%) in 16 days. Findings: Record review of Resident 1's facility's Admission Record on 12/13/24 indicated the resident was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal sugar levels in the blood), chronic kidney disease (CKD 3) (inability of the kidneys to properly filter wastes out the body), hypertension (elevated blood pressure levels) and Parkinson's (a brain disorder that causes nerve cells to die). Review of Resident 1's Weights and Vitals Summary report indicated: 4/20/24 - 204 lbs. (pounds) 4/21/24 - 204 lbs. 4/30/24 - 202 lbs. 5/2/24 - 202 lbs. 5/6/24 - 188 lbs. Resident 1 experienced a 16 pound, 7.84%, severe weight loss in sixteen days from 4/20/24 - 5/6/24. Review of Resident 1's hospital discharge report dated 4/20/24 prior to the nursing home facility admission indicated high laboratory values for blood glucose= 334 mg/dL (normal 70-100 mg/dL), and low EGFR (estimated glomerular filtration rate) = 47 (normal is greater than or equal to 60). (The EGFR is a blood test to measure how well the kidneys filter wastes out). During an interview with Resident 1's FM (family member) on 11/26/24 at 9:30 AM, the FM stated Resident 1 was alert, walking, talking, and eating when he was admitted to the facility. The FM further stated she noticed Resident 1 lost a lot of weight after being in the facility less than two weeks. According to a 2002 American Academy of Family Physicians Journal article, Involuntary weight loss can lead to muscle wasting, decreased immunocompetence, (the ability for the body to develop an immune response) depression and an increased rate of disease complications. Research has shown institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year. (www.aafp.org/afp) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a literature review of the Academy of Nutrition & Dietetics, Nutrition Care Manual, dated 2022, . Unintended weight loss is linked to increased mortality (death) among older adults . residents in long-term-care facilities who continue losing weight have a higher mortality rate compared with those who stop losing weight. Weight loss of 5% or more within 30 days is associated with a tenfold increase in the likelihood of death . https://www.nutritioncaremanual.org/ On 11/27/24 at 11:20 A.M., a joint interview and record review was conducted with the Certified Dietary Manager (CDM) and Registered Dietitian (RD). The CDM stated she was full-time, and the RD was part-time. The CDM stated the RD provided her a daily report of residents she completed assessments on based on their medical conditions. The CDM confirmed the April 2024 Medical Nutrition Therapy Assessment Recommendations document completed by the RD, had three residents who received nutrition evaluations and recommendations from 4/20/24 to 4/30/24, but Resident 1 was one of the residents. During an interview with the RD on 12/13/24 at 11:03 AM, the RD stated she conducted initial nutrition assessments on residents when they are admitted to the facility within five to seven days. The RD stated certain residents with high-risk nutrition conditions like tube feeding (use of tubes inserted in the body to obtain liquid nutrition), poor food intake within the last few days, wounds, type 2 diabetes, kidney disease, and cancer, would be assessed typically within two to three days of admission. The RD stated she typically received a phone call or text message from nursing about residents with complicated high risk nutrition conditions within 24 or 48 hours. The RD also stated she did not receive a message from nursing about Resident 1's poor meal intake for three or more days. The RD further stated all new admits and re-admits are weighed weekly then monthly thereafter. Review of Resident 1's initial nutrition assessment completed by the RD, dated 4/25/24, indicated the resident's weight was 204 pounds, desired goal weight: 190-210 pounds, labs: 240-314 BG (blood glucose) times 3 days dated 4/25/24, estimated daily calorie and protein needs: 2318-2782 kcal (calories) and 74 - 93 grams of protein . Recommendations: will continue to monitor nutritional interventions and parameters and intervene as needed. During an interview on 12/20/24 at 10:18 AM with the resident's physician (PHYS), the PHYS stated the resident was admitted to the hospital twice, but the hospital did not provide medical recommendations after he was discharged . The PHYS further stated he was informed the resident was losing weight and had poor intake for several days when he was transferred to the hospital the second time on 5/6/24. The PHYS stated it was important for residents to receive their medications and consume an appropriate diet to stabilize their health while at the facility. Review of Resident 1's history and physical (H&P) report dated 4/23/24 completed by the PHY indicated the resident had no acute distress in general appearance and was at high risk of malnutrition. A review of Resident 1's physician's diet order dated 4/20/24 indicated RCS (reduced concentrated sweets)-refers to low intake of high sugary foods), NAS (no added salt) diet, reg (Regular) texture, thin liquids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Nutrition Care plan initiated on 4/25/24, indicated the GOAL: .The resident will maintain adequate nutrition status as evidenced by maintaining weight with GWR (goal weight range) of 190-210 pounds, no s/sx (signs and symptoms) of malnutrition, and consuming at least 76-100% of meals . INTERVENTIONS: .Monitor/record/report to MD .s/sx of malnutrition: Emaciation (being abnormally weak or thin), muscle wasting, significant weight loss: 3 1bs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months .Provide, serve diet as ordered. Monitor intake and record q (every) meal. RD to evaluate and make diet change recommendations PRN (refers to as needed). Weekly weights x 4 weeks- Date Initiated: 05/03/2024 . On 1/8/24 at 9:20 AM, an interview was conducted with Licensed Nurse (LN) 7. LN 7 stated all residents were weighed when admitted and then monthly. LN 7 also stated if a resident had poor eating for three or more days, the nurses would encourage food preferences, alternatives, and snacks to get the resident to eat. And if the resident doesn't eat, then the RD and doctor is notified. LN 7 stated nursing used a calendar in a communication binder to alert the RD and facility's medical doctor, which is found at all nurse's stations. LN 7 further stated there's an alert entered in the resident's electronic medical chart when the resident consumes less than 50% of their meals for more than 3 days. On 1/8/24 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated residents are reweighed twice as a method to check the accuracy of the weight and it is compared to prior weight. The DON stated she has never seen a resident lose 16 pounds in four days like Resident 1 experienced from admission to 5/6/24. The DON stated the PHYS and RD should have been informed about Resident 1's poor meal intake of less than 50% for more than three days so they could have re-evaluated the resident and modify nutrition interventions. A review of Resident 1's April 2024 - May 2024 Meal Intake percentage (%) report indicated the resident consumed 26% to 50% of meals from April 27 through April 30 and zero to 25% of meals from May 2 through May 5, 2024, which resulted in the resident receiving an average of 600 fewer calories per day and an average of 40 fewer grams of protein per day to meet his estimated daily nutrition needs. A review of Resident's 1 change of condition document dated 5/2/24 completed by nursing, indicated the resident had general weakness/tiredness and unable to get out of bed when tired. Review of the facility's policy titled Care Plan, Comprehensive Person-Centered, dated March 2022, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility's policy titled Nutrition (Impaired)/Unplanned Weight loss- Clinical Protocol dated September 2017, indicated .Assessment: 1. The nursing staff will monitor and document the weight and dietary intake of resident . Cause: The physician will review for medical causes of .weight loss before ordering interventions .for example, high risk residents with acute symptoms such as vomiting, diarrhea, fever and infection, or those taking medications that may be causing .weight loss .Treatment decisions should consider an pertinent evidence and relevant issues (e.g., food intake, resident/ patient wishes, overall condition and prognosis, etc.) .The physician, with the help of the multidisciplinary team, will identify conditions and medications that may be causing .weight loss or increasing the risk of weight loss . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Acute Condition Changes-Clinical Protocol, dated March 2018, indicated . Assessment: .3. Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident .and how to communicate these changes to the Nurse.Treatment: The physician will help identify and authorize appropriate treatments . Review of the facility's policy titled Weighing and Measuring the Patient dated March 2011, indicated .The purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident . Review of the facility's policy titled Nutritional Assessment, dated 2017, indicated .1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission .and as indicated by a change in condition that places the resident at risk for impaired nutrition .4. The multidisciplinary team shall identify, upon admission and upon .change of condition, the following situations that places the resident at increased risk for impaired nutrition .a. Cognitive (related to thinking, reasoning, and remembering) or functional decline .b. Chewing or swallowing abnormalities .f. Increased need for calories and/or protein .g. Poor digestion or absorption . Review of the facility's policy titled Therapeutic Diets dated October 2017, indicated .4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: diabetic/calorie-controlled diet; low sodium diet; cardiac diet .8. The dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record .