

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055954	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Windsor Gardens Conv Center of San Diego		STREET ADDRESS, CITY, STATE, ZIP CODE 220 East 24th Street National City, CA 91950	

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 - 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** 49330</p> <p>Based on observation, interview, and record review, the facility staff failed to safely transfer one of five residents reviewed for pain (Resident 51) from the bed to the wheelchair, using a gait belt.</p> <p>As a result, Resident 51 sustained a fracture to the left humerus (shoulder). In addition, Resident 51's fistula (a site used for dialysis[a treatment to remove waste products from the blood]) was unusable, requiring Resident 51 to be hospitalized for the placement of a new dialysis access site.</p> <p>Findings:</p> <p>Resident 51 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease (a condition in which the kidneys cannot remove waste from the blood), dependence of renal dialysis (a treatment to remove waste products from the blood), according to the facility's Admission Record.</p> <p>On 8/19/23 at 12:20 P.M., a concurrent observation and interview was conducted with Resident 51. Resident 51 was in her room, with her lunch tray in front of her. Resident 51 was grimacing and pointing to her left shoulder and stated, Pain.</p> <p>On 8/19/23 at 12:23 P.M., an interview was conducted with Certified Nursing Assistant (CNA)1. CNA 1 stated Resident 51 complained of left shoulder pain after being transferred from her bed to wheelchair that morning. Resident 51 was assisted by two night shift CNAs. CNA 1 stated Resident 51, .is always a two-person transfer with a gait belt .</p> <p>A review of Resident 51's Emergency Department Radiology (x-ray) result, dated 8/20/24 at 12:51 A.M. indicated Resident 51 had a fracture of the left humerus.</p> <p>On 8/20/24 at 8:20 A.M., Resident 51 was observed in her room and noted to have her left arm wrapped from her wrist to her shoulder with an elastic bandage and in a sling.</p> <p>A review of Resident 51's Progress Note, dated 8/20/24 at 1:30 P.M. indicated .Dialysis cancelled .resident has severe pain in left arm due to fracture .per MD send resident to hospital for central line placement for dialysis</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24 at 6:21 A.M., an interview was conducted with CNA 2. CNA 2 stated he had not been assigned to Resident 51 for a few months. CNA 2 stated months ago, Resident 51 did not need much assistance, and he was not familiar with her current needs for help with transfers.</p> <p>CNA 2 continued, on 8/19/24, he assisted another CNA (CNA 3) to transfer Resident 51 from the bed to the wheelchair. CNA 2 stated he placed his arm under Resident 51's left arm, while CNA 3 placed her arm under Resident 51's right arm. CNA 2 stated while lifting Resident 51 from the bed, she began to slip down. CNA 2 stated he grabbed Resident 51's hand and heard, A pop. CNA 2 stated a gait belt was not used to transfer Resident 51. When asked whether CNA 2 would do anything differently the next time he transferred a resident, CNA 2 stated he would hold on tighter. CNA 2 did not mention the use of a gait belt for safe transfer.</p> <p>A review of Resident 51's Care Plan for ability to perform transfers, dated 3/14/24, indicated the resident required total assistance (all care provided by staff) for transfers.</p> <p>On 8/21/24 at 9:06 A.M., an interview was conducted with Physical Therapist (PT) 1. PT 1 stated Resident 51 required two-person, total staff assist with transfers. PT 1 stated residents who required total assistance needed a gait belt during transfers. PT 1 stated during transfers, staff should have their hands on the gait belt, not under the resident's arms. PT 1 stated Resident 51 was at risk of injury if staff used Resident 51's arms during transfer, instead of using a gait belt.</p> <p>On 8/22/24 at 3:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff should have used a gait belt while transferring Resident 51. The DON stated a safe transfer for Resident 51 meant two-person assist with a gait belt. The DON acknowledged by not using a gait belt, Resident 51 was not safely transferred from bed to chair.</p> <p>A review of facility policy titled Gait Belt, Use of, revised November 2012, indicated, .It is the policy that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer .</p> <p>A review of the facility's policy titled Safe Lifting and Moving of Residents indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .</p> <p>A review of the Facility Assessment Tool, dated 6/17/2024, indicated, Core Competencies include .transfers, using gait belt, using mechanic lifts .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49330</p> <p>Based on observation, interview, and record review, the facility failed to follow isolation precautions when contact droplet isolation (a type of isolation requiring a gown, gloves, mask and eye protection prior to entering the room) was delayed for one resident (Resident 48) with Covid-19.</p> <p>This failure had the potential to place residents and staff at risk of exposure to Covid-19 and cause the spread of infection.</p> <p>Findings:</p> <p>On 8/19/24 at 8 A.M., during the entrance conference for the facility's annual recertification survey, the Administrator (Admin)stated Resident 48 was sent to the hospital on 8/18/24 and tested positive for Covid-19. The Admin stated Resident 48 was expected back to facility on 8/19/24.</p> <p>On 8/19/24 at 8:52 A.M., an observation and interview was conducted in Resident 48's bedroom. Resident 48 was observed in his room with two roommates. Resident 48 was not wearing a face mask. Resident 48 stated he had returned from the hospital a few minutes earlier with Covid.</p> <p>On 8/19/24 at 8:55 A.M., an observation was conducted in the hallway outside Resident 48's room. A sign indicated one of Resident 48's roommates was on Enhanced Barrier Precautions (EBP, a type of isolation required only when in close physical contact with specific residents). The other two residents in the room were not indicated to be on any type of isolation.</p> <p>On 8/19/24 at 9:35 A.M., the Manager of Staff Development (MSD) stated Resident 48 should have been on Contact Droplet Isolation, not EBP, because of Resident 48's Covid-19 diagnosis. The MSD stated EBP was not enough protection from Covid-19 because it did not require a specialized face mask or eye protection. The MSD stated residents in an EBP room were not confined to the room.</p> <p>On 8/19/24 at 12:45 P.M. and 3:30 P.M., observations were conducted in the hallway outside Resident 48's room. Resident 48's roommate was still on EBP, but no additional signage for isolation precautions had been placed.</p> <p>On 8/21/24 at 10:20 A.M., an interview was conducted with the Director of Infection Prevention (DIP). The DIP stated Resident 48 should have been placed on contact droplet isolation immediately upon return from the hospital. The DIP stated .Best practice would've been to set up the room (for contact droplet precautions) prior to Resident 48's return, then the room would be contact droplet when (Resident 48) arrived. The DIP stated the facility delayed placing Resident 48 on contact droplet precautions which placed other residents, staff, and visitors at risk for contracting Covid-19.</p> <p>A review of an undated facility policy titled Covid-19 Management indicated, .A well fitting face mask should be worn by any resident that is suspected of [having] Covid-19 .Covid-19 transmission based precautions will use the following PPE .N95 respirator, gloves, gown, and eye protection .</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy revised September 2022 titled Isolation- Categories of Transmission-Based Precautions indicated, .When a resident is placed on .precautions, appropriate notification is placed on the room entrance door .so that personnel and visitors are aware of the need for and the type of precaution .		