

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/29/2025
NAME OF PROVIDER OR SUPPLIER  Helen Bernardy Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE  8060 Frost St San Diego, CA 92123	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38542</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate services were consistently implemented for four of four sampled residents (Resident 1, 2, 3, and 4) when:</p> <ol style="list-style-type: none"> <li>1) care plans were not followed</li> <li>2) the Interdisciplinary Team (IDT) recommendation was not followed</li> <li>3) care plan was not updated/revised</li> </ol> <p>As a result, there was a potential for the residents ' overall care and health to be negatively impacted.</p> <p>Findings:</p> <p>1a)Resident 1 was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a group of conditions that affect movement and posture) per the facility ' s face sheet.</p> <p>A review of records was conducted. The Physical Therapy (PT) note dated 11/22/24 indicated Resident 1 will benefit from prone [on his tummy] position under direct supervision for a minimum of 10 min, 3-4x/wk. The Multidisciplinary Summary Report dated 12/2/24 indicated the planned actions/care plan included the Clinical Activities Assistant (CAA) 1 will begin matt/tummy time per the PT recommendation. The care plan for impaired mobility and range of motion dated 11/25/24 indicated Resident 1 will participate in tummy time daily for 10 minutes.</p> <p>On 1/8/25 at 11:04 A.M., a concurrent interview and review of Resident 1 ' s tummy time flowsheet was conducted with the Administrator (ADM). There was no consistent documentation Resident 1 ' s tummy time was implemented. The ADM stated if the staff did it, it would have been documented. The ADM stated the staff should have documented if they performed the activity.</p> <p>On 1/8/25 at 11:34 A.M., a concurrent interview and review of Resident 1 ' s tummy time flowsheet with CAA 1 and the ADM was conducted. CAA 1 stated she should have documented if she did tummy time on the residents. CAA 1 stated if activities were not done, the residents could become stiff or decline. The ADM stated it was important to make sure resident activities were conducted.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at 11:28 A.M., an interview with CAA 2 was conducted. CAA 2 stated if the care plan was not implemented, the resident would not get better and their condition may reverse.</p> <p>On 1/9/25 at 12:09 P.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated it was important to follow the care plan so that the residents can maximize their potential. LN stated it was important there was documentation the care was actually done because if it was not documented, it was not done.</p> <p>On 1/21/25 at 9:30 A.M., an interview with the Activities Program Manager (MGR) 1 was conducted. MGR 1 stated the expectation was the residents ' program were being done. MGR 1 stated the staff was responsible to check and ensure the care plans were followed. MGR 1 stated the staff should have documented the program was being done on the residents.</p> <p>1b) Resident 3 was admitted to the facility on [DATE] with diagnoses which included congenital malformation (a type of birth defect) per the facility ' s face sheet.</p> <p>A review of records was conducted. The Multidisciplinary Summary Report dated 2/22/24 indicated the planned actions/care plan included Clinical Activities Assistant (CAA) 1 will walk Resident 3-4 days a week after school. The care plan for impaired mobility and range of motion dated 5/23/24 indicated Resident 3 will have ambulation with a gait trainer (a device to help a person walk safely). The Physical Therapy (PT) note dated 8/21/24 indicated Resident 3 ' s functional goal established on 8/29/23 and updated on 5/1/24 indicated for Resident 3 to stand for 1 minute and to ambulate 50 feet. Resident 3 ' s ambulation flowsheet was reviewed. There was no consistent documentation Resident 3 ' s ambulation was implemented by the staff.</p> <p>On 1/9/25 at 11:28 A.M., an interview with CAA 2 was conducted. CAA 2 stated if the care plan was not implemented, the resident would not get better and their condition may reverse.</p> <p>On 1/9/25 at 12:09 P.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated it was important to follow the care plan so that the residents can maximize their potential. LN stated it was important there was documentation the care was actually done because if it was not documented, it was not done.</p> <p>On 1/21/25 at 9:30 A.M., an interview with the Activities Program Manager (MGR) 1 was conducted. MGR 1 stated the expectation was the residents ' programs were being done. MGR 1 stated the staff was responsible to check and ensure the care plans were followed. MGR 1 stated the staff should have documented the program was being done on the residents.</p> <p>1c) Resident 4 was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a group of conditions that affect movement and posture) per the facility ' s history and physical.</p> <p>A review of records was conducted. The Care Plan Interventions note dated 3/26/20 with an expected end of 2/11/25 indicated Resident 4 was placed on a standing program. The Physical Therapy (PT) Note dated 9/10/24 indicated Resident 4 would greatly benefit from supportive walking and continued participation in a regular standing program. The PT note dated 12/4/24 indicated Resident 4 will benefit from regular weekly standing. Resident 4 ' s standing program flowsheet was reviewed. There was no consistent documentation Resident 4 ' s standing program was implemented by the staff.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at 11:28 A.M., an interview with Clinical Activities Assistant (CAA) 2 was conducted. CAA 2 stated if the care plan was not implemented, the resident would not get better and their condition may reverse.</p> <p>On 1/9/25 at 12:09 P.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated it was important to follow the care plan so that the residents can maximize their potential. LN stated it was important there was documentation the care was actually done because if it was not documented, it was not done.</p> <p>On 1/22/25 at 3 P.M., an interview with Physical Therapist (PT) 1 was conducted. PT 1 stated the expectation was for the PT recommendations to be followed by the staff. PT 1 stated if the care plan was not implemented, there was a potential for decline in endurance, strength and development of contractures.</p> <p>On 1/21/25 at 9:30 A.M., an interview with the Activities Program Manager (MGR) 1 was conducted. MGR 1 stated the expectation was the residents ' programs were being done. MGR 1 stated the staff was responsible to check and ensure the care plans were followed. MGR 1 stated the staff should have documented the program was being done on the residents.</p> <p>Per the facility ' s policy and procedure titled Care Plans dated 8/2023, 1.0 PURPOSE 1.1 To provide a documented and coordinated care plan that reflects the nursing process (problems, expected outcomes, interventions, evaluation) for each patient based on individualized needs across the continuum of care. 1.2 To provide a written means of communication of the plan of care for members of the health care team.</p> <p>2)Resident 2 was admitted to the facility on [DATE] with diagnoses which included gastrostomy (surgical opening and tube inserted into the stomach) per the facility ' s face sheet.</p> <p>A review of records was conducted. The Multidisciplinary Summary Report dated 12/30/24 indicated the planned actions/care plan included for the nursing team to remove Resident 2 ' s abdominal binder when Resident 2 was not feeding.</p> <p>On 1/8/25 at 12:15 P.M., an interview with the Administrator (ADM) was conducted. The ADM stated Resident 2 was supposed to have the abdominal binder because she plays with the gastrostomy tube during feeding and there was a concern the skin around it will break down. The ADM stated per the Interdisciplinary Team (IDT), the staff was supposed to remove Resident 2 ' s abdominal binder once feeding was done.</p> <p>On 1/8/25 at 12:21 P.M., a concurrent observation of Resident 2 and interview was conducted with Licensed Nurse (LN) 1. Resident 2 was noted feeding via the gastrostomy tube and without an abdominal binder. LN 1 stated the staff had not been using the abdominal binder since the staff was told Resident 2 had not used the binder at home. LN 1 stated there should have been a nursing communication regarding its use.</p> <p>On 1/9/25 at 12:09 P.M., an interview with LN 2 was conducted. LN 2 stated per the IDT, Resident 2 had to use the binder during feeding and removed after. LN 2 stated this needed to be clarified through nursing communication.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per the facility ' s policy and procedure titled Assessment of New Admission and Care Plan Policy dated 12/2024, .PROCEDURE: 2.0 Essential Steps in Procedure .2.5.2 Care plans are reviewed quarterly and annually by the Interdisciplinary team with the resident ' s parent and/or legal guardian to review the resident ' s progress or current health status.</p> <p>Updates to the plan of care are documented in the clinical record and signed by the members of the interdisciplinary team upon review. Goals may be updated, target dates revised or new goals initiated during this process.</p> <p>3) Resident 4 was admitted to the facility on [DATE] with diagnoses which included gastrostomy (surgical opening and tube inserted into the stomach) per the facility ' s history and physical.</p> <p>A review of records was conducted. The physician ' s progress note dated 7/9/24 and 12/4/24 indicated it was not safe for Resident 4 to each [sic] by mouth per Occupational Therapy (OT) and the resident was clinically aspirating. The Multidisciplinary Summary Report dated 12/9/24 indicated Resident 4 needed a consult with OT due to family feeding the resident solid foods for oral gratification. The speech therapist note dated 12/7/24 indicated the goal of speech referral was to trail tastes of purees with the intent to re-complete swallow study when [patient] is ready.</p> <p>On 1/9/25 at 10:09 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 4 ' s father fed Resident 4 with small pieces of bread by mouth. The DON stated the recommendation was to feed the resident with pureed (liquidized/crushed) food.</p> <p>On 1/9/25 at 12:13 P.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated Resident 4 ' s father was observed feeding Resident 4 by mouth. LN 2 stated Resident 4 had pneumonia in the past and it was mentioned Resident 4 had aspiration.</p> <p>Per the facility ' s policy and procedure titled Assessment of New Admission and Care Plan Policy dated 12/2024, .PROCEDURE: 2.0 Essential Steps in Procedure .2.5.2 Care plans are reviewed quarterly and annually by the Interdisciplinary team with the resident ' s parent and/or legal guardian to review the resident ' s progress or current health status.</p> <p>Updates to the plan of care are documented in the clinical record and signed by the members of the interdisciplinary team upon review. Goals may be updated, target dates revised or new goals initiated during this process.</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate services were consistently implemented for four of four sampled residents (Resident 1, 2, 3, and 4) when:</p> <ol style="list-style-type: none"> <li>1) care plans were not followed</li> <li>2) the Interdisciplinary Team (IDT) recommendation was not followed</li> <li>3) care plan was not updated/revised</li> </ol> <p>As a result, there was a potential for the residents' overall care and health to be negatively impacted.</p> <p>(continued on next page)</p>		

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