

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Sharp Chula Vista Med Ctr Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Medical Center Court Chula Vista, CA 91911	

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** 38542</p> <p>Based on observation, interview and record review, the facility failed to ensure a care plan was developed to ensure one of three sampled resident's safety (Resident 1).</p> <p>As a result, restricted persons were able to visit the resident in the facility.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included ill-defined liver mass concerning for malignancy per the facility's History and Physical.</p> <p>On 6/27/24 at 10:50 A.M., an observation of Resident 1's room was conducted. There was a sign next to the door to see the nurse prior to visiting the resident.</p> <p>On 6/27/24 at 11:15 A.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated there was an Adult Protective Services (APS) case opened for Resident 1 because Resident 1's family member expressed concern that Resident 1's properties were transferred to the neighbors. LN 2 stated the family member informed the facility the name of the person who was not allowed to visit Resident 1.</p> <p>On 6/27/24 at 11:33 A.M., a concurrent interview and record review with Social Worker (SW) 1 were conducted. SW 1 stated Resident 1's family member was concerned Resident 1 had a visitor who the family member believed had stolen money from Resident 1. Per the SW, the family member also stated concern that Resident 1 had signed over forms to her neighbors giving them her property and became Resident 1's executor. SW 1 stated she confirmed with Resident 1 these allegations were true and informed Resident 1 she would file an APS report which the resident agreed to. SW 1 stated the physician ordered a psychiatrist consult for Resident 1 which was conducted on 6/11/24 and which determined the resident did not have the capacity to give or refuse to give informed consent for financial decision making.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 1:39 P.M., a concurrent interview and review of visitor logs with Social Worker (SW) 1 were conducted. SW 1 stated she filed the APS report for Resident 1 on 6/4/24. SW 1 stated she informed the facility Resident 1 was not supposed to have contact with her neighbor on 6/5/24. SW 1 stated on 6/7/24, she informed the staff of the person who allegedly stole money from the resident but she did not document that she did. The visitor logs indicated the neighbor visited Resident 1 on 6/6/24 and the person who allegedly stole money from the resident visited Resident 1 on 6/7/24, 6/11/24, 6/12/24 and 6/13/24.</p> <p>On 6/27/24 at 12:31 P.M., an interview with the Director Of Nursing (DON) was conducted. The DON stated the staff should have been aware there were people who cannot visit Resident 1. The DON stated the visitors could gain access to the resident before the staff would know they were there.</p> <p>On 6/27/24 at 3:02 P.M. an interview with Certified Nurse Assistant (CNA) 2 was conducted. CNA 2 was not able to identify who the restricted visitors were for Resident 1.</p> <p>A review of Resident 1's records was conducted. There was no care plan ensuring how to keep Resident 1 safe after the APS report was filed. In addition, there was no documentation there were restricted visitors for Resident 1.</p> <p>On 7/8/24 at 3:15 P.M, an interview with the DON was conducted. The DON stated there was no care plan created for Resident 1 after the APS report was done for Resident 1. The DON stated the SW should have created a care plan for Resident 1 after the report.</p> <p>On 7/8/24 at 3:52 P.M., an interview with LN 4 was conducted. LN 4 stated she was aware there was an APS report filed for Resident 1 but was not able to articulate what it was about. LN 4 stated the sign next to Resident 1's door regarding visitation should have been at the facility entrance instead because visitors could have been inside the resident's room already if they did not see the nurse prior to visiting the resident.</p> <p>On 7/8/24 at 4 P.M., an interview with LN 5 was conducted. LN 5 stated she was not aware what the actual APS issue was about.</p> <p>On 7/8/24 at 4:15 P.M., an interview with CNA 3 was conducted. CNA 3 stated she was not aware there were people not allowed to visit Resident 1 and that there was an APS report filed.</p> <p>On 7/8/24 at 4:18 P.M., an interview with CNA 4 was conducted. CNA 4 stated she was not aware there were people not allowed to visit Resident 1 and that there was an APS report filed. CNA 4 stated the facility should have informed the staff who were allowed and not allowed to visit Resident 1.</p> <p>Per the facility's policy and procedure titled Care Plan/Interdisciplinary Care Conference dated 1/12/22, .III. Plan of Care will be .3. Reviewed and revised by IDT members as needed weekly, with significant changes .</p>		