

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8778 Cuyamaca Street Santee, CA 92071	

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** 38175</p> <p>Based on observation, interview, and record review, the facility failed to develop a resident-centered care plan for one of five residents (Resident 2) reviewed for care plan development. Resident 2 was identified to be at high risk for fall which was not reflected in the resident ' s care plan.</p> <p>This failure had the potential for staff to not be aware of Resident 2 ' s fall risk, which could potentially result in staff not providing the appropriate fall intervention to prevent fall incidents.</p> <p>Findings:</p> <p>Resident 2 was readmitted to the facility on [DATE] with diagnoses that included abnormalities of gait (manner of walking) and mobility (ability to move) according to the Admission Record.</p> <p>A review of Resident 2 ' s Fall Risk Evaluation, dated 5/3/24, indicated that Resident 2 was at High Risk for fall.</p> <p>A review of Resident 2 ' s care plan, dated 5/3/24, indicated a problem titled At Risk for Fall. An interview and joint record review was conducted with the Clinical Care Coordinator (CCC) on 8/16/24 at 12:55 P.M. The CCC acknowledged that Resident 1 ' s fall care plan did not reflect the resident ' s individual concern and needs. The CCC stated Resident 1 ' s care plan should be developed to meet the resident's needs. The CCC stated it was important to develop a resident-centered care plan because each patient needs were different, and the residents' individual needs should be met.</p> <p>A review of the facility ' s policy and procedure titled Care Planning-Interdisciplinary Team, revised March 2022, indicated, . 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38175</p> <p>Based on interview and record review, the facility failed to revise one of five residents ' (Resident 3) care plan related to fall risk.</p> <p>This failure resulted in the miscommunication of Resident 3 ' s fall risk among the healthcare provider, which could potentially result in fall incidents.</p> <p>Findings:</p> <p>A review of Resident 3 ' s Admission Record indicated that the resident was readmitted to the facility on [DATE] with diagnoses that hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body).</p> <p>A review of Resident 3 ' s Fall Risk Assessment, dated 12/26/23, indicated the resident was at moderate risk for fall.</p> <p>A review of Resident 3 ' s Fall Risk Assessments, dated 2/20/24, 3/20/24, and 6/17/24, indicated the resident was at high risk for fall.</p> <p>A review of Resident 3 ' s care plan related to fall, dated 8/11/23, indicated Resident 3 was at Moderate Risk for Falls.</p> <p>An interview and joint record review of Resident 3 ' s medical record was conducted on 8/16/24 at 12:55 P. M. with the Clinical Care Coordinator (CCC). The CCC acknowledged that Resident 3 ' s fall care plan did not reflect the resident ' s current fall risk. The CCC stated Resident 3 ' s care plan should have been revised, for staff to know the resident ' s actual fall risk and interventions to prevent fall incidents.</p> <p>A review of the facility ' s policy and procedure title Care Planning-Interdisciplinary Team, revised March 2022, provided no guidance regarding staff ' s responsibility related to the revision of care plans.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 38175</p> <p>Based on interview and record review, the facility failed to ensure that one of five residents (Resident 21) was free from future falls when the facility failed to conduct a thorough investigation of Resident 21 ' s fall.</p> <p>This failure has the potential to cause a fall with injury to Resident 21 as the facility was not able to determine the cause of Resident 21 ' s fall and implement specific interventions to prevent future falls.</p> <p>Findings:</p> <p>During a review of Resident 21 ' s admission record, Resident 21 was admitted to the facility on [DATE] with a diagnosis of diverticulitis (inflammation or infection in one or more small pouches of the intestines), morbid obesity, other abnormalities of gait and mobility. Resident 21 ' s fall risk assessment dated [DATE], indicated Resident 21 was a high risk for falls.</p> <p>During a review of Resident 21 ' s progress notes, Resident 21 had a fall on 8/3/24. According the Interdisciplinary (IDT) note dated 8/5/24, .Per resident, she wanted to get up and tried to brace herself but fell on the floor .</p> <p>During a concurrent interview and record review with the Clinical Care Coordinator (CCC) conducted on 8/16/24 at 2:12 P.M., the CCC stated the investigation of Resident 21 ' s fall was not thorough. The CCC stated that staff should have investigated what Resident 21 was trying to do when the resident attempted to stand up on her own. The CCC stated thorough investigations were needed to determine the root cause of the fall. The CCC stated that thorough investigations were needed in order to come up with effective fall interventions.</p> <p>A review of the facility ' s policy and procedure titled, Falls - Clinical Protocol, dated 3/2018, indicated .The staff and practitioner will begin to try to identify possible causes within 24 hours of the fall .</p>		