

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER San Diego Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 South Orange Ave. El Cajon, CA 92020	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46247</p> <p>Based on interview and record review the facility failed to ensure a physician's order was followed when nursing staff did not do vital signs every four hours for one COVID-19 (a highly contagious respiratory disease) positive resident (1) who was transferred and later died at the hospital.</p> <p>This deficient practice delayed the gathering of vital information about Resident 1's condition and potentially impacted the transfer of care to the hospital.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with a diagnosis of emphysema (a lung condition that causes shortness of breath) per the facility ' s face sheet.</p> <p>Resident 1 tested positive for COVID-19 on [DATE] per the facility's infection control note, dated [DATE].</p> <p>A review of Resident 1's physician's orders, dated [DATE], indicated Resident 1's vital signs (clinical measurements of essential body functions including: blood pressure, pulse rate, temperature, respiration rate, and oxygen saturation level), were ordered to be monitored every four hours for a positive diagnosis of COVID-19.</p> <p>On [DATE] at 1:45 P.M., an interview was conducted with certified nursing assistant (CNA) 1 at the facility. CNA 1 stated CNAs are responsible for taking vital signs of all COVID-19 positive residents at the beginning of the shift and whenever else the licensed nurse (LN) directs them to take vital signs. CNA 1 stated abnormal vital signs are reported to the LN immediately. CNA 1 stated vital signs for all residents are documented in the resident's electronic health record.</p> <p>On [DATE] at 2:16 P.M., an interview was conducted with LN 1 at the facility. LN 1 stated vital signs were monitored every four hours for COVID-19 positive residents. LN 1 stated abnormal vital signs such as a high heart rate, high temperature, high blood pressure or low oxygen need to be reported to the physician immediately and documented in the resident's electronic health chart.</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:33 P.M., a telephone interview was conducted with LN 2. LN 2 stated COVID-19 positive resident's need their vital signs taken every four hours and LN's are to report any abnormal vital signs to the doctor immediately. LN 2 stated vital signs were obtained by the CNAs or the LNs but it was the LN's responsibility to ensure they are done. LN 2 stated COVID-19 positive resident's condition can worsen quickly so it is important to obtain and report abnormal vital signs as ordered by the doctor. LN 2 stated all vital signs are recorded in the resident's electronic health record.</p> <p>On [DATE] at 1:45 P.M., a concurrent interview and record review of Resident 1's electronic health record (EHR) was conducted with the assistant director of nursing/Infection Preventionist (ADON/IP). The ADON/IP stated it was the facility's policy and expectation that vital sign monitoring, which included temperature (T), pulse (P), oxygen level (O2 sat), respirations (RR) and blood pressure (BP), was conducted every four hours and documented in the electronic medication administration record (EMAR) or progress notes. A review of Resident 1's EHR was conducted with the ADON/IP.</p> <p>A review of all progress notes, dated [DATE], and the facility document titled Weights and Vitals Summary (WVS),, effective date range [DATE] - [DATE], indicated, the first set of full vital signs (BP, O2 sat, P, R, T) for Resident 1 obtained on [DATE] at 3:44 AM and were:</p> <p>BP: ,d+[DATE]O2 sat: 95%P: 85 bpm (beats per minute)R: 18, T: 98.1 degrees Fahrenheit (F)</p> <p>The next full set of vital signs in the WVS were documented on [DATE] at 12:43 P.M.</p> <p>A review of the progress note titled Alert Note, dated [DATE] at 12:31 P.M., indicated, .At 11:15 noted resident . temp 100.4 F . BP ,d+[DATE] HR 112 RR 22 spo2% 91 3L NC (nasal cannula) . rechecked an hour later . temp 101.4, spo2 85% 3L NC , HR,d+[DATE], gently repositioned resident to sit up, increased o2 5L NC, husband request to send resident out to hospital, respiratory therapist came with o2 tank and mask and nonrebreather. spo2 91% on 5L NC, then went down to 85%, HR ,d+[DATE]s. Reported change in LOC, desaturation, and fever to MD with new orders to send resident out via 911 .</p> <p>The ADON/IP acknowledged no vital signs had been obtained and documented anywhere in the EHR on [DATE] between the hours of 3:44 A.M. and 11:15 A.M. The ADON/IP acknowledged seven and a half hours elapsed between nursing obtaining vitals for Resident 1 and this exceeded the standard four hour time interval ordered by the doctor. The ADON/IP The ADON/IP stated VS not documented in the HER indicated they were not obtained. The ADON/IP stated abnormal vital signs were considered any change from a resident's normal vital sign measurements and should be reported to the doctor immediately. The ADON/IP stated changes in a COVID-19 positive resident's vital signs happen quickly and if they were not monitored as ordered it could cause a delay in getting care the resident would need.</p> <p>A review of the facility policy titled Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents, revised [DATE], indicated, Policy Statement: Strategies used for the rapid identification and management of SARS-COV-2 infected residents are consistent with current recommendations from the Centers for Disease Control and Prevention. Policy Interpretation and Implementation . Clinical Care . 19. Clinical monitoring of residents with suspected or confirmed SARS-CoV-2 infection is increased, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection .</p>		