

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER The Springs at Pacific Regent		STREET ADDRESS, CITY, STATE, ZIP CODE 3884 Nobel Drive San Diego, CA 92122	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</p> <p>Based on interview and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice for one resident (1) reviewed for wound care and treatment.</p> <p>This deficient practice placed Resident 1 at risk for harm related to poor wound healing and infection.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of type two diabetes mellitus (health condition in which the body is unable to regulate blood sugar levels; can lead to complications of poor circulation and multi-system problems with the eyes, heart, kidneys, and limbs [arms, legs]), per Resident 1's Admission Record.</p> <p>A record review of Resident 1's Minimum Data Set (MDS- nursing assessment tool that is used to develop a plan of care) dated 6/21/24 , indicated a Brief Interview for Mental Status (BIM- developed by reviewing the resident's status during the prior seven day period) score of 15 points out of 15 possible points which indicated Resident 1 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>On 9/4/24 at 11:25 A.M., an interview, and record review was conducted with the infection prevention (IP) nurse. The IP nurse stated that Resident 1 tested positive for COVID-19 (a highly contagious respiratory disease caused by the SARS virus) on 6/21/24. The IP nurse stated that Resident 1 had a surgical wound appointment on 6/21/24 for her recent right below-the-knee amputation (RBKA; surgery- removal of a limb/body part because of injury or disease, such as diabetes), but missed the appointment due to a positive COVID-19 test. The IP stated that once Resident 1 was cleared from COVID-19 precautions, she had an appointment scheduled on 7/2/24 for vascular surgery and 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/4/24 at 2:13 P.M., an interview and record review was conducted with licensed nurse (LN) 1. LN 1 stated that Resident 1 had daily wound treatments for her RBKA site. LN 1 acknowledged that the treatment administration record (TAR) dated 6/21/24 with the order that indicated Treatment: Surgical Incision site: RBKA-Cleanse area with WD (wound) cleanser, pat dry, apply xeroform, gauze, wrap it with kerlix and ACE (elasticized bandage) wrap with Amusheild [sic], daily dressing change; f/u with [MD NAME] 6/21/24 . was blank. LN 1 stated that Resident 1's wound treatment was not done because it was not checked off. LN 1 stated that on 6/27/24, she documented 8 (eight) meaning absent from facility and stated that Resident 1 was still on isolation precautions due to COVID-19, so she (Resident 1) should had been in the facility. However, LN 1 futher stated that she thought Resident 1 had dialysis that day, and was out of the facility. LN 1 stated this was the reason why she did not do (provide) Resident 1's wound treatment. LN 1 stated it was important to do daily dressing changes per Medical Doctor's (MD) orders for Resident 1's RBKA surgical wound because Resident 1's has a history that compromised circulation to her limb, due to type two diabetes mellitus, which can affect wound healing and cause infection complications.</p> <p>On 9/4/24 at 12:28 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated she would have to re-educate the licensed nurses to help with wound treatments if the wound nurse is unable to complete a treatment and/or assist if needed. The ADON stated it was important to do daily wound treatments for Resident 1 because complications such as growth of bacteria to surgical site, cellulitis (skin infection), worsening of wounds, and prolonged wound healing that can send Resident 1 back to the hospital.</p> <p>On 9/5/24 at 3:15 P.M., an interview was conducted with LN 2. LN 2 stated she was the wound nurse on 6/22/24 and 6/23/24 for Resident 1. LN 2 stated that on 6/22/24 with Resident 1's RBKA surgical wound treatment, she was unsure why she had charted eight that indicated absent from facility. LN 2 acknowledged that Resident 1 had tested positive for COVID-19 on 6/21/24 that indicated that Resident 1 was still in the facility due to isolation precautions. LN 2 stated that on 6/23/24 she had charted seven to indicate see nurses notes and stated she would usually put a nursing note, but acknowledged there were no nurses' notes written by her, regarding Resident 1's RBKA surgical wound treatment. LN 2 stated I can't re-call her [Resident 1] specifically an amputee if I did any treatments on her because of the COVID-19 outbreak at the facility.</p> <p>On 9/6/24 at 12:28 P.M., an interview was conducted with the ADON. The ADON stated Resident 1 had diabetes and was at risk for complications of infection and poor wound healing due to poor circulation and slower healing with wounds especially with someone with diabetes and further amputation of the limbs to potentially lose more of her [Resident 1]'s extremity. The ADON stated it was important for Resident 1's RBKA surgical wound treatments to be done daily, per MD orders. In addition, the ADON stated her expectations was for [the wound nurse/nurses] to include progress notes about Resident 1's RBKA surgical wound care but with no progress notes I don't know what happened that day.</p> <p>A review of the facility's undated policy and procedure titled, CARE AND TREATMENT WOUND MANAGEMENT, indicated It is the policy of this facility to identify, assess and treat wounds on admission or throughout our residents stay .</p>		