STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint # CA00717009 Category: Infection Control Quality of Care/Treatment Dietary Services The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 39111. DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY (see F684).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) received care and treatment in accordance to professional standards of practice, when: 1. Resident 1 was not provided a follow-up	F 684	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident no longer resides in the facility. Resident who has Medical appointments	8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/20/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 physician appointment after a surgical procedure, as was ordered. 2. Resident 1's significant weight loss of 5.31% was not reported to the resident's physician. These failures had the potential for Resident 1 to experience post surgical complications and to continue to lose weight. Findings: Resident 1 was admitted to the facility on 11/24/20 with diagnoses to include fracture of unspecified part of neck of right femur (broken hip), per the facility's Admission Record. 1. On 12/24/20 at 12:50 P.M., a telephone interview was conducted with general acute care hospital (GACH) social worker (SW). The SW stated Resident 1 had presented to the GACH emergency room on 12/16/20. SW stated Resident 1 still had the sutures in place from the hip surgery that was done during GACH stay on 11/20/21 through 11/24/20. The SW stated Resident 1 had been discharged to the skilled nursing facility on 11/24/20 following the GACH stay. The SW stated the facility had not ensured Resident 1was provided an appointment with his orthopedic surgeon within 10 days of discharge. On 12/24/20, GACH documentation was reviewed. Social Work Progress Note, dated 12/16/20, indicated, "...Pt [patient] admitted at [GACH name omitted] from 11/20-11/24, R [right] femoral neck fx [fracture]... Pt had surgery, percutaneous pinning of the hip [use of pins/screws to hold broken bones together]. Discharge instructions indicate pt was to f/u w/	F 684	have been audited by the Resident□s Relation employee and case manager on August 19 and August 20, 2021 to ensure that all medical appointments are being followed and that schedules are being made with corresponding transportation to ensure that all appointments are being done. No other residents were found to be affected by this deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this action. DON/ADON has provided education to all licensed nurses including the Resident Relation staff to make sure every time a resident has a medical appointment it should be communicated and written in the calendar at the nurses station and in PCC, our electronic health record. In-services conducted on August 8,10,11,16,17 of 2021. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Medical Records Director/ designee will monitor compliance by conducting daily Audits for any new admissions, changes of conditions that require follow-up medical appointments. 4. How the facility plans to monitor its performance to make sure that solutions are sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 surgeon [name omitted] within 10 days of d/c [discharge]... Pt upset w/ care at SNF [skilled nursing facility], reported SNF did not assist w/ post-surgical f/u for appt [appointment] w/ surgeon, nor removal of sutures...." On 12/29/20, a facility record review was conducted. Resident 1's GACH Discharge/Home Care Instructions, dated 11/24/20, indicated, "...Follow-up Instructions...with [surgeon's name and address omitted] In 10 days...Call for follow up appointment..." Resident 1's physician's orders, dated 11/24/20, indicated, "f/u [follow-up] with [surgeon's name and contact information omitted] in 10 days." On 12/29/20 at 3:45 P.M., a joint interview and record review was conducted with licensed nurse (LN) 2. LN 2 stated it was the facility's responsiblility to coordinate follow-up care and treatment with another provider. LN 2 stated the unit clerk scheduled residents' follow-up appointments. LN 2 stated the unit clerk had been on a leave of absence and she was not sure who had assumed the responsibility of scheduling appointments. LN 2 reviewed Resident 1's clinical record and stated there was no documentation the resident had a surgical follow-up appointment scheduled. LN 2 stated there was documentation Resident 1 had been to his post surgical follow-up visit. LN 2 reviewed the facility's appointment book located in the nurses' station. LN 2 stated Resident 1 had not been scheduled for a follow-up appointment. LN 2 stated Resident 1 was not provided a follow-up visit with his surgeon as was ordered. LN 2 stated this should not have happened.	F 684	MDS Nurse will also monitor compliance by assessing and checking orders of newly admitted residents, including but not limited to any medical appointments. Findings will be discussed daily by the ID team/ nursing supervisor. Any necessary follow-up action will be developed and implemented immediately. The findings will be reported to the Quality Assurance Committee and further follow up action done as needed. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident no longer resides in the facility. Resident who has weight gain/loss of 2% weekly, 5% in 30 days and 10% in 180 days were audited by ADON on August 19, 2021 to ensure that any resident affected has documentation and that the MD was notified and that a Care Plan was formulated. No other residents were found to be affected by this deficient practice 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this action. DON and ADON has provided educations to all licensed nurses including RNA□s on August 8,10,11,16,17 of 2021 to ensure that in the event that RNA□s are weighing residents, any weight gain/loss should be reported to licensed nurse. Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 Resident 1 could not be interviewed. On 1/21/21 at 10:05 A.M., a joint interview and record review was conducted with the director of nursing (DON). The DON reviewed Resident 1's clinical record and stated the resident's follow-up appointment with the surgeon had not been arranged. The DON stated, "He [Resident 1] got missed." The DON stated Resident 1 was at the facility from 11/24/20 through 12/16/20, and there had been enough time to provide the resident with a follow-up appointment. The DON stated Resident 1's follow-up appointment had been a physician's order which had not been carried out. The DON stated a follow-up appointment with Resident 1's surgeon should have been arranged and the facility should have made sure the resident went to the appointment. The DON further stated the facility did not have a policy to guide coordinating follow-up appointments. The DON stated she was unable to find a policy that guided following physician's orders. The DON stated following physician's orders was a professional standard of nursing practice, and it was her expectation for physician orders to be carried out. 2. On 12/24/20 at 12:50 P.M., a telephone interview was conducted with general acute care hospital (GACH) social worker (SW). The SW stated Resident 1 had presented to the GACH emergency room on 12/16/20. The SW stated Resident 1 had appeared "very thin" and had lost weight during his stay at the facility. On 12/29/21 at 2:40 P.M., an interview was conducted with licensed nurse (LN) 1. LN 1 stated all residents were weighed weekly during their first month residing in the facility. LN 1	F 684	nurse will documented and reported to MD and will formulate care plan within 72 hours. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: ADON/ Licensed nurse designee will audit weight changes every 1st and 2nd day of the week to ensure any changes have been properly documented and MD together with the family are being notified. Care plan will be formulated within 72 hours. 4. How the facility plans to monitor its performance to make sure that solutions are sustained: DON will conduct random checks weekly to verify that weight changes are being monitored and documented in a timely manner. Findings will be discussed daily by the ID team/nursing supervisor. Any necessary follow-up action will be developed and implemented immediately. The findings will be reported to the Quality Assurance Committee and further follow up action done as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

stated any significant or severe weight losses had to be reported to the resident's physician and the registered dietitian. LN 1 stated a significant or severe weight loss in a week or month was considered a change of condition.

On 12/29/20, a record review was conducted. Resident 1's weekly weights were:

11/27/20 130.6 lbs
12/7/20 131.8 lbs
12/12/20 124.8 lbs

There was no documentation Resident 1's weekly weight loss of seven lbs on 12/12/20 (a 5.31 % weight loss) had been reported to the resident's physician. Furthermore, there was no documentation Resident 1's weight loss had been planned, or was desired.

According to the State Operations Manual, dated November 2017, a resident's weight loss of five percent in one month was considered significant, and more that five percent was considered severe.

Resident 1 could not be interviewed.

On 12/29/20 at 3:30 P.M., an interview and record review was conducted with restorative nursing assistant (RNA) 1. RNA 1 stated the RNAs weighed residents and compared their recent weight to the previous weight. RNA 1 stated a weight gain or loss of five pounds or more had to be reported to LN 1. RNA 1 reviewed Resident 1's weekly weights and stated Resident 1 lost seven lbs on 12/12/20. RNA 1 stated this should have been reported to LN 1. RNA 1 stated she could not recall if it had been reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD COURT SKILLED NURSING & REHAB CENTER	8778 CUYAMACA STREET SANTEE, CA 92071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 On 1/21/21 at 10:05 A.M., a joint interview and record review was conducted with the director of nursing (DON). The DON stated Resident 1's weight loss of 5.31% on 12/12/20 was considered significant weight loss. The DON stated significant weight loss was considered a change of condition and had to be reported to the resident's physician within 24 hours. The DON stated any weekly weight loss of five or more pounds also had to be reported to the resident's physican for immediate action. The DON stated this had to be done in order to prevent further weight loss. The DON reviewed Resident 1's clinical record and stated there was no documentation the resident's physician or the facility's registered dietitian been notified that Resident 1 lost seven pounds, or 5.31%, on a weekly weight (12/12/20). The DON stated Resident 1 weight loss had been unplanned. The DON stated Resident 1's care plan had not been updated to reflect significant weight loss and appropriate interventions. The DON stated she would expect nursing to create a written care plan to address the significant weight loss once the physician had been notified. The DON stated a change of condition required a care plan update and that this was considered a standard of nursing practice. The DON further reviewed the facility's policy titled Weight Management, dated 6/16/16, and stated the policy did not provide guidance for notifying the physician and registered dietitian of a resident's significant weight loss. The DON stated promptly notifying the physician and registered dietitian of a resident's significant weight loss was "best practice."	F 684		