



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2011
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ESCONDIDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1980 FELICITA ROAD ESCONDIDO, CA 92025		
(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) COMPLETE DATE
A 000	Initial Comments The following represents the findings of the California Department of Public Health during a complaint investigation. Complaint No.: CA00266082 The investigation was limited to the specific complaint event and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: HFEN 27942	A 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
A 201	T22 DIV5 CH3 ART3-72315(f) Nursing Service-Patient Care (f) Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include: This RULE: is not met as evidenced by: Based on interview and record review the facility failed to provide Patient A care to prevent formation and progression of decubiti by not turning the patient every two hours as indicated in the patient's care plan. Findings: Patient A was admitted to the facility on 7/25/10 with diagnoses that include Alzheimer's and dementia per the facility Face Sheet. During a joint interview and record review, on 4/18/11 at 1:30 P.M., the Wound Care Nurse (LN 1) acknowledged that Patient A had been assessed as a high risk for pressure ulcer development and a care plan, dated 8/16/10,	A 201	Please accept this Plan of Correction as our allegation of compliance.   1. Patient A is no longer at this facility. Current residents who have been assessed as a high risk for pressure ulcer development will be turned every two hours as indicated in the care plan to prevent formation and progression of decubiti.	

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

STATE FORM

021199

UO5D11

If continuation sheet 1 of 3

Algoria Prado, RN

D.O.N.

08/15/11

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A 201	<p>Continued From Page 1</p> <p>listed an approach for every two hour, and as needed, turning to prevent pressure ulcer development. LN 1 stated, " On Thursday (1/13/11) she was okay and on Monday (1/17/11) she had a stage II pressure ulcer on her coccyx. " LN 1 further acknowledged that the Pressure Ulcer Status Record, dated 1/15/11, indicated Patient A had developed a 1cm (centimeter) by 0.5 cm stage II (a partial thickness loss of skin layers) pressure ulcer on her coccyx (commonly referred to as the tailbone).</p> <p>During an interview and record review, on 4/22/11 at 3 P.M., LN 1 acknowledged that in the three days prior to the assessment of the stage II pressure ulcer, 1/15/11, it had not been documented that Patient A had been turned every two hours on 5 of the 9 shifts, per the CNA (Certified Nursing Assistant) Monthly Flow Report and that could have led to the pressure wound development.</p> <p>During an interview and record review, on 5/13/11 at 1:25 P.M., the DON acknowledged that Patient A ' s care plan indicated the facility would turn her every two hours and as needed. A review of the CNA Monthly flow Report for Patient A indicated that Patient A had only been turned during 56 of the 93 shifts in the month of January. The DON confirmed that the facility had failed to ensure Patient A was turned every two hours, as indicated in the care plan, during 37 of 93 shifts in January 2011 and that could have led to the development of the stage II pressure ulcer discovered on 1/15/11. The DON acknowledged that the CNA ' s had failed to document turning Patient A every two hours and that failing to turn the patient per the care plan could have resulted in the pressure ulcer occurrence.</p>	A 201	<p>2. During the weekly skin rounds, residents at risk for pressure ulcer development will be identified and will be given appropriate care to prevent further skin breakdown, contractures, and deformities. The Wound Care Nurse will assess and develop a plan of care to prevent formation and the progression of decubiti. This will be communicated to the Charge Nurse and C N A who are responsible for these residents. The Charge Nurse and/or RN Supervisor will be responsible to ensure that residents are being turned every two hours as indicated in the care plan and documented in the C N A Monthly Flow Reports. The ED and/or DON will be made aware of the weekly skin assessment report by the Wound Care Nurse.</p>	

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			<p>3. An in-service on primary risk factors, treatment plan, and prevention of formation and progression of pressure ulcer, will be given by the DSD to the nursing staff. The importance of documentation of the plan of care will also be emphasized to the staff.</p> <p>4. Compliance will be monitored through random medical records review and the C N A Monthly Flow Reports review by the DSD and/or ADON. Results will be reported to the monthly CQI meeting until compliance is met. Additional action plan shall be formulated as needed. ED/DON will oversee. Date certain: 08/31/11</p>		

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