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 _____	08/29/2011

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

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A 000	Initial Comments The following reflects the findings of the California Department of Public health during the investigation of a complaint. Complaint #: CA00251481 Category: Quality of Care The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: HFEN 28343 The investigation resulted in the issuance of one deficiency under the Health & Safety Code and one deficiency under Title 22. The following represent the AMENDED findings of the California Department of Public Health during the investigation of a complaint, and subsequent to an Informal Conference which was held by the Department on August 11, 2011. This 2567 reflects the additional deficiency written under Title 22, §72311(a)(1)(A). Complaint # CA00251481 Category: Quality of Care The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Health Facilities Evaluator Nurse 29269	A 000	With the submission of this plan of correction. Stanford Court Nursing Center declares a credible allegation of compliance related to the hereafter mentioned deficiencies. Without the admission of guilt, the following plan of correction is submitted. SAN DIEGO REGIONAL ... OFFICE SEP 30 2011 CA DEPT OF PUBLIC HEALTH	9/9/11

le ncies are cited, an approved plan of correction is requisite to continued program participation.

BU ...TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anner Bakeloke	Administrator	9/9/11

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A 161	Continued From Page 1	A 161		
A 161	T22 DIV5 CH3 ART3-72311(a)(1)(A) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. This RULE: is not met as evidenced by: Based on interview and record review the facility failed to implement measures to reduce the swelling of Patient A's right ankle, after she was assisted to the floor on 11/19/10. Findings: Patient A was admitted to the facility on 10/14/10, with diagnoses that included bilateral ankle contractures, per the Record of Admission. On 11/19/10 at 1:20 P.M., Licensed Nurse 1 (LN 1) documented in the Nurses Notes she received report from a Certified Nursing Assistant (CNA) that Patient A was assisted to the floor during transfer and was experiencing increased pain to the right ankle. LN 1 further documented, "Ankle assessed. Warm, tender to touch and swollen. No bruising or abrasion noted." At 1:50 P.M., LN 1 further documented the patient's daughter was in the facility and had been updated on the situation.	A 161	A-161 1. Corrective action Patient discharged. 2. Any resident that is assisted to the floor has the potential to be affected. 3. The licensed nurses were inserviced on 9/8/11 to provide interventions for any swollen limb as a result of being lowered to the floor by staff. Example: ice application to affected extremity, elevation to edema, assess for pain, medicated for pain as ordered, monitor for increased edema. Notify MD of increase pain and increase swelling. The nurses were inserviced to notify the nursing supervisor of patient lowered to floor by the staff when the incident occurs. The nursing supervisor will review interventions implemented to ensure they are appropriate.	9/9/11

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A 161	Continued From Page 2 On 11/19/10, nursing staff implemented a care plan for Patient A: Concern: Increased pain/swelling right ankle. Goal: Free of pain x 72 hours. Approach: Notify physician of increased pain/swelling. Obtain stat X-Ray. Medicate as needed for pain. Send to Emergency Room (ER) for further evaluation and treatment. The staff did not document on Patient A's care plan the initiation of any measures to reduce swelling of the right ankle, or monitor circulation of the right foot and ankle, such as elevation of the leg or application of ice The staff also did not document in the Nurses Notes circulation checks of Patient A's foot, elevation the right leg, or application of ice to reduce the swelling.. On 11/19/10 at 4:34 P.M., the results of the x-ray indicated, "Ankle swelling but no fracture." On 11/19/10 at 5 P.M., LN 2 documented Patient A transported via ambulance to ER, accompanied by daughter. On 8/11/11, during an informal conference, Family Member 1 (FM 1) stated when she saw Patient A on 11/19/10 at approximately 1:30 P.M., the patient was sitting in a wheelchair and her right leg was swollen. FM 1 further stated an X-Ray was taken at 4:34 P.M. Patient A was sent to the ER at 5 P.M. and diagnosed with severe ankle sprain. FM 1 also stated the staff did not elevate Patient A's right leg elevated, or apply ice to reduce the swelling. During the informal conference, representatives from the facility could not provide any evidence that measures were taken immediately after the	A 161	Continued from page 2. 4. The nursing supervisor will monitor every shift times 72 hours that the interventions are effective. The director of nurses will be notified immediately of any change of condition related to patient being lowered to the floor. DON will present finding to the QA committee and update as needed.	9/9/11

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A 161	Continued From Page 3 patient was assisted to the floor, to reduce the swelling that was observed by staff and family members.	A 161		9/9/11
A 993	T22 DIV5 CH3 ART5-72547(a)(5)(C) Content of Health Records (a) A facility shall maintain for each patient a health record which shall include: (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials. This RULE: is not met as evidenced by: Based on interview and record review,the facility failed to ensure that a PRN (as needed) dose of Tylenol (a non-narcotic pain medication) given to one patient (Patient A) was documented in the Medication Administration Record (MAR). Findings: Patient A was admitted to the facility on 10/14/10, according to the Record of Admission.	A 993	A-993 1.Corrective action Resident discharged. 2.How other residents having the potential to be affected will be identified. All residents with orders for PRN medication will be identified as having the potential to be affected. 3.Systems/measures The Licensed Nurses have been inserviced by the Director of Nurses and the Director of Staff Development on 12/10/10 and 6/20/11 of the need to record PRN medications given on the Medication Administration Record with the results of the effectiveness of the medication using the pain scale 0-10.	

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A 993	Continued From Page 4 According to the licensed nurse's (LN 1) note, dated 11/9/10 at 1:20 P.M., Patient A was lowered to the floor during an attempted transfer on 11/19 10, at 1:20 P.M. Patient A complained of right ankle pain after the incident. LN 1's assessment of Patient A's right ankle indicated that it was warm, tender to the touch, and swollen. Patient A's clinical record was reviewed on 12/10/10 at 10 A.M. Per the nurse's notes, LN 1 gave Patient A Tylenol for her complaint of pain; however, the time, date, and dose of the PRN Tylenol was not located in the MAR. An assessment-rating of Patient A's level of pain before and after the Tylenol was given was not documented in the MAR; LN 1's initials were not located in the appropriate place on the MAR. LN 1's full signature, on the back of the PRN medication sheet, was not entered in the MAR.	A 993	4.Monitor The Medical Records Director will review PRN medication sheets given on a weekly basis to ensure the medication given includes the date, time, medication and the effectiveness of the medication using the pain scale 0-10. Negative findings will be reported to the Director of Nurses for follow up actions.. Results will be reported to the QA Committee by the Director of Nurses.	9/9/11