STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. BUILDING _____ B. WING _____	C 06/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN DIEGO HEALTHCARE CENTER	2828 MEADOWLARK DRIVE SAN DIEGO, CA 92123

(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 survey. Complaint Number: CA00482221 The investigation was limited to the specific complaint and the investigation does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Health Facilities Evaluator Nurse #17131 A deficiency was identified under the Code of Federal Regulations. Glossary of Abbreviations: ADL -- Activities of Daily Living DON -- Director of Nursing CNA -- Certified Nursing Assistant LN -- Licensed Nurse P/P -- Policy/Procedure	F 000	This plan of correction constitutes the facility's credible allegation of compliance. Life House San Diego Healthcare Center submits this response and plan of correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. RECEIVED CA DEPT OF PUBLIC HEALTH JUN 17 2016 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE	7-5-16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	Corrective Action: The certified nursing assistants will be re-in-serviced on the necessity of accurate documentation of bowel movements and the requirement that documentation reflects the specific category that corresponds on the form where the bowel movement is being recorded.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pat Van Natta	Executive Director	6-16-16

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.

POC and Evidence of Correction Accepted w/Deficiencies HFES 6/17/16.

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F 514	Continued From page 1 preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: Based on interview and record review, the facility staff failed to accurately document BMs (bowel movements) for Resident 1. As a result, recorded BMs did not indicate actual constipation (BMs less often than normal) status. Findings: Resident 1 was admitted to the facility on 3/24/15 with diagnoses which included dementia and enlarged prostate, per the admission record. Resident 1's hospital discharge History and Physical, dated 3/23/16, listed diagnoses which included aspiration pneumonia (food/fluid particles entered the lung) and significant constipation. On 3/30/16 at 8 A.M., in a telephone interview, the complainant said Resident 1 was diagnosed constipated when sent to the hospital on 3/18/16. On 5/2/16 at 1:30 P.M., Resident 1's March, 2016, Resident 1's CNA-ADL Flow Sheet record of BMs was reviewed with the DON. Between 3/1/16 and 3/18/16, approximately 28 entries were marked with the size of the BM corresponding with S-M-L (small, medium, large). Approximately nineteen (19) entries were marked with a number starting with zero though three (3). Four entries were marked with the number eight (8) which had no meaning to the category. On 5/2/16 at 1:45 P.M., CNA 1, who worked the day shift, said she counted a smear of stool on a brief as a BM.	F 514	Identification: All residents have the potential to be affected. Certified Nursing Assistants shall be re-in-serviced on the necessity of accurate documentation of bowel movements and the requirement that documentation reflects the specific category that corresponds on the form where the bowel movement is recorded. Measures/System: Accurate documentation, including but not limited to documentation of bowel movements and use of the specific category shall be part of the orientation of the new certified nursing assistants conducted by the Director of Staff Development.	7-5-16

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F 514	Continued From page 2 On 5/2/16 at 2:15 P.M., CNA 2, who worked the evening shift, said she only recorded small, medium and large amounts of BM, not smears. CNA 2 said the resident's BMs were only charted on the ADL-Flow Sheet. On 5/2/16 at 2:45 P.M., the DON acknowledged Resident 1's BM documentation did not make sense and that licensed staff would have a difficult time interpreting the entries to decide if a resident needed the laxative. On 5/3/16 at 10:45 A.M., in a telephone interview, LN 1 acknowledged Resident 1's record of BMs was not accurate. LN 1 said she asked the CNA if it was really important, but that was time consuming. LN 1 said residents' BM activity was only recorded on the ADL Flow Sheet. Per the CNA - ADL TRACKING FORM (XFM 050699R) instructions indicated staff were to "record # of episodes, movements, as appropriate." Per the American Health Information Management Association's Practice Brief entitled, Update: Maintaining a Legally Sound Health Record-Paper and Electronic, Journal of AHIMA 76, no.10 (November-December 2005): 64A-L, indicated, "Regardless of the format, text entries should follow fundamental principles for the quality of the entry. Content should be specific, objective, and complete. Use specific language and avoid vague or generalized language."	F 514	Monitoring: As part of the ongoing monitoring process, there shall be random visual checks of the documentation of the bowel movements recorded to ensure the documentation reflects the specific meaning to the category on the record, on a monthly basis for three months. To be conducted by medical records staff member. The findings will be reported to the Director of Staff Development and Director of Nurses. On a quarterly basis, as part of the Quality Assurance review, the findings will be reported to the Quality Assurance Committee for review and a plan of action as necessary. To be monitored by the Medical Records Supervisor, the Director of Staff Development, Director of Nurses, and Quality Assurance Committee.	7-5-16