

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Kearny Mesa Convalescent and Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7675 Family Circle Drive San Diego, CA 92111	
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision for one of two residents reviewed for falls (Resident 1).As a result, Resident 1 was left unsupervised, fell and sustained a hip fracture. Findings:According to the undated admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses to include abnormalities of gait (a person's manner of walking) and mobility (the ability to move freely and easily) and dementia (a progressive state of decline in mental abilities).According to the physician's History and Physical (H&P), dated 6/26/26, Resident 1 had impaired mobility due to multiple hospital stays. The H&P indicated Resident 1 had poor recall, poor memory, and had no capacity to understand her medical condition. The H&P indicated Resident 1 had generalized weakness, needed assistance, and was at the facility for therapy. According to the Minimum Data Set (MDS, an assessment tool) dated 7/2/26, Resident 1 had moderately impaired cognition. According to the Fall Risk Evaluation form, dated 6/25/26, Resident 1 was at high risk for falls due to three or more falls in the last 90 days, age greater than 85 years, three or more medications which contribute to fall risk, intermittent confusion, impaired walking, and impaired gait and/or balance. According to a Change in Condition Evaluation (CIC), dated 6/26/26, Resident 1 had an unwitnessed fall in the facility dining room. The CIC indicated Resident 1 was last seen sitting in a wheelchair. Per the CIC, Resident 1 complained of severe pain to her right hip and right leg. According to a Health Status Note, dated 6/26/26, Resident 1 was admitted to the hospital with a right femoral neck fracture (hip fracture). An interview was conducted with the Director of Nursing (DON) on 7/22/26 at 11:30 A.M. The DON stated all residents were considered to be at risk for falls. If a resident was at high risk for falls, they would be monitored closely and not left unattended. Per the DON, Resident 1 had an unwitnessed fall in the dining room. An activity had just finished, and the Activity Assistant (AA) who led the activity was taking residents back to their rooms. The DON stated Resident 1 and another resident were the last two remaining in the dining room, and the AA had placed Resident 1 in the hallway outside of the dining room within view of nursing staff. Per the DON, a daily meeting was conducted to brief staff of new admissions, CICs, or other high risk safety concerns. The DON stated the daily meeting was the main way staff communicated about residents. The DON stated reeducation had been done for Activities and nursing staff that residents at high risk for falls should, .always have eyes on them.An interview was conducted with the Activity Director (AD) on 7/22/26 1:30 P.M. Per the AD, she was not present when Resident 1 fell. The AD stated the music activity was being led by the AA. The AD stated the AA was returning residents to their rooms by himself, and normally this would also be done by other staff, like nurses or Certified Nursing Assistants (CNAs). The AD stated all residents are considered to be at risk for falls. Per the AD, she believed the AA had moved Resident 1 into the hallway outside of the (continued on next page)		

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room when the activity was finished, so nurses would be able to monitor Resident 1. The AD stated although the AA had placed Resident 1 in a high visibility area, he had not informed the nurses of the need to monitor Resident 1 for safety. An interview was conducted with CNA 1 on 7/22/26 at 3:45 P.M. CNA 1 stated a recent staff education session on fall prevention was conducted. CNA 1 stated the inservice reminded staff that new residents or residents with dementia were never to be left alone as they were unaware of their environment. CNA 1 stated the key takeaway message was to communicate with coworkers. A follow up telephone interview was conducted with the DON on 7/28/26 at 2 P.M. The DON stated when a resident had dementia, it was important to do more frequent monitoring, and to keep them in a high visibility area. The DON stated inside the dining room was not considered a high visibility area. A telephone interview was conducted with the AA on 7/28/26 at 2:10 P.M. The AA stated Resident 1 had attended a music activity on 6/26/26. The AA stated when the activity ended, he placed Resident 1 outside of the dining room where the nurses could monitor her. The AA stated he saw a nurse in the hallway but did not inform her Resident 1 needed monitoring. Per the AA, he later heard that Resident 1 had fallen. The AA stated he did not know much about Resident 1 since she was a new admission. The AA stated he was not aware of her dementia diagnosis or that she was at high risk for falls. The AA stated that the AD would brief staff on new admissions, or any special precautions like high fall risk. Per the AA, he did not recall being informed of Resident 1's high fall risk by the AD. The AA stated that after Resident 1 fell, he had received additional training on communication with staff. According to a facility policy, revised March 2018 and titled Falls and Fall Risk, Managing, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling .		