STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055488	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Mesa Healthcare Center	3780 Massachusetts Avenue LA Mesa, CA 91941

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff adhered to infection prevention and control practices for one of three sampled residents (Resident 2) when:Resident 2's urinary catheter and tubing (a flexible, hollow tube inserted into the bladder to drain and collect urine) was touching the floor and was not placed inside the catheter bag (fabric bag used to conceal urinary collection bag). This failure had the potential for cross-contamination (spread of germs and bacteria) and posed an infection to residents, staff, and visitors.Findings:A review of admission Record for Resident 2 indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis that included Acute Kidney Failure (kidneys suddenly can't filter waste products from the blood). During a facility tour on 4/29/26 at 11:10 A.M., Resident 2 was observed inside the room with a Foley catheter drainage bag touching the floor beside the bed where it remained for an undetermined amount of time. On 4/29/26 at 11:50 A.M., an observation and interview was conducted with Certified Nurse Assistant (CNA 1) in Resident 2's room. CNA 1 stated the Foley catheter, and tubing should not touch the floor and that the urine bag must be placed inside the catheter bag. CNA 1 stated this was to prevent infections to the resident. On 4/29/26 at 2:25 P.M., an interview with an Infection Preventionist (IP) was conducted. The IP stated Foley catheters should be hung on the low side of the residents' bed and not touch the floor. The IP stated the urine bag should be placed inside a catheter bag. The IP stated his expectation was for all nursing staff to adhere to infection control practices. On 4/29/26 at 4:30 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Foley catheters should never touch the floor and should be maintained in urine catheter bag to prevent cross-contamination. The DON stated her expectations was for nursing staff to strictly adhere to infection control practices. A review of the facility's policy titled Catheter Care, Urinary, dated 2001, indicated .2. Be sure the catheter tubing and drainage bag are kept off the floor

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