

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909</p> <p>Based on observation, interview, and record review, the facility failed to address resident's needs for one of three sampled residents (Resident 2) when Resident 2's lower denture was not applied during meals.</p> <p>This failure had the potential to affect Resident 2's well-being, comfort, and safety while dining.</p> <p>Findings:</p> <p>Resident 2 was admitted to the facility on [DATE] with diagnoses which included a history of dementia (loss of memory), muscle weakness, and communication deficit, per the Admission Record.</p> <p>A review of Resident 2's nursing care plan (NCP; document that outlines the nursing care required for a specific patient) dated 12/21/21, indicated that Resident 2 had upper and lower dentures that needed to be worn during meals, and removed at night.</p> <p>An observation was conducted on 3/24/25 at 9:34 A.M. inside Resident 2's room. Resident 2 was eating without her dentures in place. A lower denture was observed inside a denture cup placed on the table.</p> <p>A follow-up observation and interview was conducted with licensed nurse (LN) 2 on 3/25/25 at 9:01 A.M. Resident 2 was eating breakfast without a denture on. LN 2 stated that Resident 2's lower denture was inside the denture cup that was on the bedside table. LN 2 further stated that a nursing staff should have applied the denture inside Resident 2's mouth so that Resident 2 may chew and eat properly.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/26/25 at 4:05 P.M. The DON stated that NCPs should be implemented by the health care team. The DON acknowledged that Resident 2's dentures should have been applied during meals, as instructed on the care plan.</p> <p>The facility's policy titled Dentures, Cleaning and Storing revised 3/2018, indicated, .Preparation .2.1. Review the resident's care plan to assess for any special needs of the resident General Guidelines 4' Encourage the resident to keep dentures in his or her mouth .</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270</p> <p>Based on observation, interview, and record review, the facility failed to ensure the central venous catheter (a tube inserted into a large vein near the heart to allow for long-term access to the bloodstream for medications, fluids, blood draws, and other treatments) was changed and monitored for two of two sampled residents (292 and 297).</p> <p>This failure had the potential for complications related to intravenous (IV - method of delivering fluids, medications, or nutrients directly into the bloodstream through a vein) therapy.</p> <p>Findings:</p> <p>Per the facility's admission record, Resident 292 was admitted on [DATE] with diagnoses that included right ankle and right foot osteomyelitis (infection of the bone).</p> <p>A review of Resident 292's physician's orders indicated, on 3/20/25 an order was made to change IV dressing every day every Sunday.</p> <p>On 3/24/25 at 10:45 A.M., an observation and interview were conducted with Resident 292 in her room. Resident 292 had an IV line on the right upper arm. Resident 292 stated a nurse changed the dressing yesterday. Resident 292 could not recall if the nurse measured her arm or the IV catheter.</p> <p>On 3/24/25 at 11:15 A.M., an observation and interview were conducted with Resident 297 in his room. Resident 297 had an IV line on the right upper arm. Resident 297 stated a nurse changed the dressing yesterday and he could not recall if the nurse measured his arm or the IV catheter.</p> <p>On 3/26/25 at 8:38 A.M., a concurrent interview and record review was conducted with LN 3. A review of the Peripherally Inserted Central Catheter (PICC) line dressing change documentation dated 3/23/25 in the IV Medication Administration Record (MAR) for both Residents 292 and 297 indicated, measurements of arm circumference and catheter length were not done. LN 3 stated the importance of measuring arm circumference and the catheter length for a central venous catheter was to ensure proper placement and prevent complications.</p> <p>On 3/27/25 at 2:25 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that measuring arm circumference and the catheter length for a central venous catheter during the dressing change was a standard of practice and should have been done.</p> <p>A review of the facility's policy titled Central Venous Catheter Care and Dressing Changes, dated 2001, indicated .6. Measure the length of the external central vascular access device with each dressing .measure arm circumference .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610</p> <p>Based on observation, interview and record review, the facility failed to provide interventions to prevent the redevelopment of pressure injuries (skin damaged by lack of movement for staying in a position for too long) and accurately assessed residents for skin injury for two of three residents reviewed for pressure injuries (Resident 16 and Resident 20).</p> <p>As a result, Resident 16 redeveloped a pressure injury on her left buttock and Resident 20 developed a new pressure injury on her left buttock.</p> <p>Findings:</p> <p>1. A review of Resident 16's Admission Record indicated Resident 16 was readmitted to the facility on [DATE], with diagnoses which included generalized muscle weakness.</p> <p>Resident 16's attending physician completed Resident 16's history and physical (H&P) dated 6/14/24. The H & P indicated Resident 16 was able to make own decisions.</p> <p>Resident 16's minimum data set (MDS - a federally mandated resident assessment tool), completed on 1/30/25, indicated Resident 16's brief interview for mental status (BIMS, ability to recall) score was 13/15 (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Resident 16's MDS for functional abilities from lying on back to roll to left and right side indicated Resident 16 needed moderate staff assistance which meant the helper (staff) lifts, holds or supports resident's trunk or limbs.</p> <p>During an observation and an interview of Resident 16 in her room on 3/24/25 at 10:22 A.M., Resident 16 laid in bed, with low air loss mattress (designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown). Resident 16 stated she had no concerns.</p> <p>A review of the facility's matrix (used to identify pertinent care categories) indicated, Resident 16 had a stage 3 (extend through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone) facility acquired pressure injury on her left buttock.</p> <p>A review of Licensed Nurses (LN) progress notes dated 3/7/25, 3/8/25, 3/9/25, and 3/10/25 indicated, Resident 16 had a small open wound at the buttock and was placed on alert charting. There was no physician order and no documentation from the treatment nurse.</p> <p>A review of LN's weekly summary notes completed by LN 22, dated 3/13/25 and 3/20/25 indicated, Resident 16 had no skin injury.</p> <p>A review of Resident 16's skin assessment completed by the wound care nurse (WCN) on 3/17/25, indicated, Resident 16 had stage 3 pressure injury on her left buttock and measured as follows:</p> <ul style="list-style-type: none"> - Area 0.7 centimeter (cm, metric of measurement), - Length 0.9 cm. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Width 1.1 cm.</p> <p>- Depth 0.2 cm.</p> <p>The WCN's skin assessment notes for Resident 16 indicated, Resident 16's onset of her pressure injury was unknown. The skin assessment notes indicated, the pressure injury had moderate serosanguinous (type of wound drainage) exudate.</p> <p>During an observation and an interview of Resident 16 in her room on 3/25/25 at 3:58 P.M., Resident 16 was slightly lying on her right side. Resident 16 stated she had open wound on her buttocks.</p> <p>During a record review of Resident 16's clinical record and a joint interview with the Wound Care Nurse (WCN) on 3/26/25 at 2:20 P.M., the WCN stated she was familiar with Resident 16. The WCN stated Resident 16 needed some help from the staff when turning or repositioning herself in the bed. The WCN stated Resident 16 had history of stage 3 pressure injury on her left buttock and was resolved. The WCN stated night shift CNAs notified her about Resident 16's open wound on her left buttock on 3/17/25. The WCN stated, It was already stage 3. The WCN stated she was not aware Resident 16 had an open wound from 3/7/25 and she was notified on 3/17/25. The WCN stated there was no documentation that Resident 16 was receiving treatment on her open wound on her left buttock. The WCN stated the nurses should have informed her or the doctor so treatment could have been started for Resident 16's open wound. The WCN stated it can be preventable.</p> <p>During an interview with the Director of Nursing (DON) on 3/26/25 at 3:24 P.M., the DON stated the LNs should have done the treatment, it was not only monitoring and alert charting. The DON stated the LNs should have followed it up with the physician and informed the wound care nurse so treatment should have been started. The DON further stated the staff should have repositioned the resident every two hours especially Resident 16 had history of open wounds on her left buttock. The DON stated, This is preventable.</p> <p>A review of the facility's policy, titled Prevention of Pressure Injuries, revised 4/2020, indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors .Skin Assessment, 1. Conduct a comprehensive skin assessment .with each risk assessment, as identified according to the resident's risk factors .3. Inspect the skin on a daily basis when performing or assisting with personal care .Monitoring, 1. Evaluate, report .potential changes in the skin .</p> <p>45909</p> <p>2. Resident 20 was admitted to the facility on [DATE] with diagnoses which included a history of muscle weakness, abnormal mobility, and fracture of the vertebra (spine), per the Admission Record.</p> <p>A review of Resident 20's nursing care plan (NCP- document that outlines the nursing care required for a specific patient) dated 11/10/23, indicated that Resident 20 was at risk for skin breakdown.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A wound observation and interview was conducted with the Wound Care Nurse (WCN) on 3/25/25 at 9:55 A. M. inside Resident 20's room. Resident 20's left buttock was purple in color. The WCN stated that a deep tissue injury (DTI- skin breakdown caused by prolonged pressure) was identified on Resident 20's left buttock when Resident 20 was assessed on 1/6/25. The WCN stated that Resident 20's left buttock DTI would have been prevented with accurate skin assessment and appropriate skin treatment.</p> <p>A concurrent interview and record review was conducted with Licensed Nurse (LN 3) on 3/25/25 at 2:30 P.M. Resident 20's nursing weekly summary (NWS- detailed nursing documentation completed by the LN every week; included a summary of assessment and comprehensive care that was provided to the resident) dated: 12/26/24 included documentation that Resident 20 had no skin breakdown.</p> <p>1/1/25 included documentation that Resident 20 had no skin breakdown.</p> <p>1/8/25 included documentation that Resident 20 had skin breakdown that was discovered on 1/6/25.</p> <p>LN 3 stated that Resident 20's DTI on the left buttock would have first appeared as a stage 1 (skin redness). LN 3 acknowledged that Resident 20's DTI would have been prevented with accurate nursing assessment, prompt communication, and skin treatment.</p> <p>An interview was conducted with the DON on 3/26/25 at 4:09 P.M. The DON acknowledged that LNs should accurately assess and document a resident skin condition to prevent further skin breakdown.</p> <p>The facility's policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 3/2014 indicated, Assessment and Recognition .2.In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909</p> <p>Based on observation, interview and record review, the facility failed to provide a safe environment related to activity of daily Living (ADL - everyday task) for one of three sampled residents (Resident 59) when Resident 59 used a disposable razor while unsupervised.</p> <p>This failure had the potential to affect Resident 59's safety and well- being.</p> <p>Findings:</p> <p>Resident 59 was admitted to the facility on [DATE] with diagnoses which included right eye vision loss and heart failure.</p> <p>A review of Resident 59's physician order dated 4/17/24 indicated, Aspirin (ASA- medication that can cause bleeding) one tablet by mouth, every day for cerebrovascular accident (CVA-blockage of the brain) prophylaxis (prevention).</p> <p>A concurrent observation and interview was conducted on 3/24/25 at 9:23 A.M with Resident 59. Resident 59 was observed shaving her chin with a disposable razor. Resident 59 stated that she shaved her chin everyday by herself.</p> <p>An interview and record review was conducted with licensed nurse (LN) 1 on 3/25/25 at 3:53 P.M. LN 1 stated that per Resident 59's physician order for ASA, Resident 59 was at risk for bleeding. LN 1 further stated that Resident 59 should had been supervised or assisted by staff while she shaved her chin.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/26/25 at 4:07 P.M. The DON stated that staff should assist residents to prevent accidents. The DON acknowledged that Resident 59 had right eye vision loss and was on ASA. The DON stated that Resident 59 should have not shaved her chin by herself to prevent accidental cut and bleeding.</p> <p>The facility's policy titled Shaving the Resident revised 2018, indicated, .Preparation 1. Review the resident's care plan to assess for any special needs of the resident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610</p> <p>Based on observation, interview, and record review, the facility staff failed to consistently monitor and document urine output (UO) per the facility's policy, for four of six sampled residents (7, 10, 11 and 12) with a urinary catheter (a tube inserted into the bladder to aid in urine flow). In addition, there was no urinary catheter care order for Residents 7, and 12.</p> <p>These failures had the potential for residents 7, 10, 11 and 12 to have urinary retention and develop urinary tract infection (UTI).</p> <p>Findings:</p> <p>1a. Resident 7 was readmitted to the facility on [DATE], with diagnoses which included sepsis (a serious condition in which the body responds improperly to an infection), per the facility's Admission Record.</p> <p>Resident 7's attending physician completed Resident 7's history and physical (H & P) dated 2/13/25. The H & P indicated, Resident 7 was not able to make own decisions.</p> <p>On 3/24/25 at 9:32 A.M., an observation and an interview of Resident 7 was conducted in her room. A urinary catheter was attached to Resident 7's wheelchair. Resident 7 stated she was in pain and will go to the nurse's station.</p> <p>A review of the physician's order dated 2/12/25, indicated for the staff to measure Resident 7's urine output for 30 days.</p> <p>On 3/26/25 at 9:53 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 7 had a urinary catheter, and one responsibility of the CNAs was to measure residents' urine output. CNA 21 stated the measurement would be in milliliter (ml, metric of measurement) and should be documented in the resident's clinical record.</p> <p>On 3/26/25 at 11:15 A.M., a review of Resident 7's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 7 was alert with moments of confusion. LN 23 stated Resident 7 had a urinary catheter and Resident 7's urine output should be monitored every shift and documented in her clinical record. LN 23 stated there were missed documentation of urine output for Resident 7 in March 2025: 3/9, 3/14, 3/17 through 3/19, 3/21, and 3/23/25 in the evening shifts. LN 23 stated Resident 7's urine output should have been monitored and documented consistently to ensure she was not retaining urine and prevent UTI.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for residents with urinary catheter was, the nurses should have consistently measured the residents' urine output and documented in the residents' clinical record. The DON stated it was important to identify if the resident was retaining any fluid to prevent resident from acquiring UTI.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Input/ Output, 1. Observe the resident's urine level for noticeable increases or decreases .2. Follow the facility procedure for measuring and documenting .output .</p> <p>A review of the facility's policy, titled Output, Measuring and Recording, revised 10/2010, indicated, The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period .Steps in the Procedure .8. Record the amount noted on the output side of the .output record. Record in mls .</p> <p>1b. On 3/24/25 at 9:32 A.M., an observation and an interview of Resident 7 was conducted in her room. A urinary catheter was attached to Resident 7's wheelchair. Resident 7 stated she was in pain and will go to the nurse's station.</p> <p>On 3/26/25 at 9:53 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 7 had a urinary catheter, and the responsibility of the CNA was to empty the urine bag.</p> <p>On 3/26/25 at 11:15 A.M., a review of Resident 7's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 7 was alert with moments of confusion. LN 23 stated Resident 7 had a urinary catheter. LN 23 stated the physician's order indicated to change and irrigate the urinary catheter. There was no catheter care order for Resident 7.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for the residents with urinary catheter was, the nurses should have verified the residents' physician for urinary catheter care order. The DON stated there should be a documentation that catheter care was provided to residents with urinary catheter to prevent infection. The DON stated the expectation was the LNs were responsible to clean the insertion site.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Perineal care, 1. Use soap and water or bathing wipes for routine daily hygiene .Documentation, The following information should be recorded in the resident's medical record, 1. The date and time that catheter care was given .</p> <p>2. Resident 10 was readmitted to the facility on [DATE], with diagnoses which included UTI, per the facility's Admission Record. Resident 10's attending physician completed Resident 10's history and physical (H & P) dated 2/12/25. The H & P indicated, Resident 10 did not have the capacity to understand and make decisions.</p> <p>On 3/24/25 at 9:36 A.M., an observation of Resident 10 was conducted in her room. Resident 10 laid in bed with eyes closed and did not respond to her name. There was a urinary catheter hanged at Resident 10's bed rails.</p> <p>A review of the physician's order dated 3/4/25, indicated for the staff to measure Resident 10's urine output in mls (milliliter, metric of measurement) every shift for 30 days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/26/25 at 9:41 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 10 was confused, had a urinary catheter, and one responsibility of the CNAs was to measure residents' urine output. CNA 21 stated the measurement would be in mls and documented in the resident's clinical record.</p> <p>On 3/26/25 at 11:10 A.M., a review of Resident 10's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 10 was alert with moments of confusion. LN 23 stated Resident 10 had a urinary catheter and Resident 10's urine output should be monitored every shift and documented in her clinical record. LN 23 stated there were missed documentation of urine output for Resident 10 in March 2025: 3/13, 3/14, 3/18 through 3/21, and 3/24/25 for the whole 24-hour shift. LN 23 stated, in addition, there were missed monitoring and documentation of urine output for Resident 10 in the following dates and shifts. 3/15/25 night shift, 3/16/25 night and morning shifts, 3/17/25 morning and evening shifts, 3/22/25 night and morning shifts, 3/23/25 morning shift, 3/25/25 night and morning shifts, and 3/26/25 night shift. LN 23 stated Resident 10's urine output should have been monitored and documented to ensure she was not retaining urine and prevent UTI.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for residents with urinary catheter was, the nurses should have consistently measured the residents' urine output and documented in the residents' clinical record. The DON stated it was important to identify if the resident was retaining any fluid to prevent resident from acquiring UTI.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Input/ Output, 1. Observe the resident's urine level for noticeable increases or decreases .2. Follow the facility procedure for measuring and documenting .output .</p> <p>A review of the facility's policy, titled Output, Measuring and Recording, revised 10/2010, indicated, The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period .Steps in the Procedure .8. Record the amount noted on the output side of the .output record. Record in mls .</p> <p>3. Resident 11 was readmitted to the facility on [DATE], with diagnoses which included sepsis (a serious condition in which the body responds improperly to an infection), per the facility's Admission Record.</p> <p>Resident 11's attending physician completed Resident 11's history and physical (H & P) dated 9/30/24. The H & P indicated Resident 11 was able to make own decisions.</p> <p>On 3/24/25 at 10:13 A.M., an observation and an interview of Resident 11 was conducted in his room. Resident 11 laid in bed watching TV. There was a urinary catheter hanged at Resident 11's bed rails. Resident 11 stated he did not have concerns at the moment.</p> <p>A review of the physician's order dated 3/4/25, indicated for the staff to measure Resident 11's urine output in mls (milliliter, metric of measurement) every shift for 30 days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/26/25 at 9:56 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 11 knew what was going on and oriented, had a urinary catheter, and one responsibility of the CNAs was to measure residents' urine output. CNA 21 stated the measurement would be in mls and documented in the resident's clinical record.</p> <p>On 3/26/25 at 11:35 A.M., a review of Resident 11's clinical record and an interview was conducted with Licensed Nurse (LN) 21. LN 21 stated Resident 11 was alert, oriented and knew what was going on. LN 21 stated Resident 11 had a suprapubic catheter (a urinary catheter that is inserted into the bladder from a small cut in your tummy, just above your pubic bone). LN 21 stated Resident 11's urine output should be monitored every shift and documented in his clinical record. LN 21 stated there were missed documentation of urine output for Resident 11 in the following dates and shifts: 2/28/25, 3/2/25, 3/7/25, 3/8/25, 3/12/25, 3/24/25 night shifts, and 3/3/25 evening shift. LN 21 stated the purpose of monitoring the urine output for the resident with urinary catheter was to make ensure the resident did not retain fluids to prevent UTI. LN 21 further stated it was important to know if the catheter was patent.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for residents with urinary catheter was, the nurses should have consistently measured the residents' urine output and documented in the residents' clinical record. The DON stated it was important to identify if the resident was retaining any fluid to prevent resident from acquiring UTI.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Input/ Output, 1. Observe the resident's urine level for noticeable increases or decreases .2. Follow the facility procedure for measuring and documenting .output .</p> <p>A review of the facility's policy, titled Output, Measuring and Recording, revised 10/2010, indicated, The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period .Steps in the Procedure .8. Record the amount noted on the output side of the .output record. Record in mls .</p> <p>4a. Resident 12 was readmitted to the facility on [DATE], with diagnoses which included UTI, per the facility's Admission Record. Resident 12's attending physician completed Resident 12's history and physical (H & P) dated 3/5/25. The H & P indicated, Resident 12 can make needs known but could not make medical decisions.</p> <p>On 3/24/25 at 9:27 A.M., an observation and an interview of Resident 12 was conducted in her room. Resident 12 laid in bed watching TV. A urinary catheter was hanged at Resident 12's bed rails. Resident 12 stated she felt good.</p> <p>A review of the physician's order dated 3/3/25, indicated for the staff to measure Resident 12's urine output in mls (milliliter, metric of measurement) every shift for 30 days.</p> <p>On 3/26/25 at 9:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 12 was alert with period of confusion, had a urinary catheter, and one responsibility of the CNAs was to measure residents' urine output. CNA 21 stated the measurement would be in mls and documented in the resident's clinical record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/26/25 at 11:04 A.M., a review of Resident 12's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 12 was able to make her needs known. LN 23 stated Resident 12 had a urinary catheter and Resident 12's urine output should be monitored every shift and documented in her clinical record. LN 23 stated there were missed documentation of urine output for Resident 12 in March 2025: 3/3 through 3/7, 3/10 through 3/12, 3/13 through 3/24, 3/17 through 3/21, and 3/24/25 for the whole 24-hour shift. LN 23 stated, in addition, there were missed monitoring and documentation of urine output for Resident 12 in the following dates and shifts. 3/8, and 3/9 night and evening shifts, 3/15, 3/16, 3/22, and 3/25 night and morning shifts, and 3/23 morning shift. LN 23 stated Resident 12's urine output should have been monitored and documented to ensure she was not retaining urine and prevent UTI.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for residents with urinary catheter was, the nurses should have consistently measured the residents' urine output and documented in the residents' clinical record. The DON stated it was important to identify if the resident was retaining any fluid to prevent resident from acquiring UTI.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Input/ Output, 1. Observe the resident's urine level for noticeable increases or decreases .2. Follow the facility procedure for measuring and documenting .output .</p> <p>A review of the facility's policy, titled Output, Measuring and Recording, revised 10/2010, indicated, The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period .Steps in the Procedure .8. Record the amount noted on the output side of the .output record. Record in mls .</p> <p>4b. On 3/24/25 at 9:27 A.M., an observation and an interview of Resident 12 was conducted in her room. Resident 12 laid in bed watching TV. A urinary catheter was hanged at Resident 12's bed rails. Resident 12 stated she felt good.</p> <p>On 3/26/25 at 9:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 12 was alert with period of confusion, had a urinary catheter, and the responsibility of the CNA was to empty the urine bag.</p> <p>On 3/26/25 at 11:04 A.M., a review of Resident 12's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 12 was able to make her needs known. LN 23 stated Resident 12 had a urinary catheter. LN 23 stated there was no urinary catheter care order for Resident 12. LN 23 stated the wound care nurse (WCN) was responsible for providing the catheter care to the residents with catheter. LN 23 further stated, I don't know how to do that foley (urinary catheter) care.</p> <p>On 3/26/25 at 2:20 P.M., an interview was conducted with the WCN. The WCN stated the LNs who passed medications were responsible in providing catheter care to residents with urinary catheter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for the residents with urinary catheter was, the nurses should have verified the residents' physician for urinary catheter care order. The DON stated there should be a documentation that catheter care was provided to residents with urinary catheter to prevent infection. The DON stated the expectation was the LNs were responsible to clean the insertion site.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Perineal care, 1. Use soap and water or bathing wipes for routine daily hygiene .Documentation, The following information should be recorded in the resident's medical record, 1. The date and time that catheter care was given .</p> <p>4b. On 3/24/25 at 9:27 A.M., an observation and an interview of Resident 12 was conducted in her room. Resident 12 laid in bed watching TV. A urinary catheter was hanged at Resident 12's bed rails. Resident 12 stated she felt good.</p> <p>On 3/26/25 at 9:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21 stated Resident 12 was alert with period of confusion, had a urinary catheter, and the responsibility of the CNA was to empty the urine bag.</p> <p>On 3/26/25 at 11:04 A.M., a review of Resident 12's clinical record and an interview was conducted with Licensed Nurse (LN) 23. LN 23 stated Resident 12 was able to make her needs known. LN 23 stated Resident 12 had a urinary catheter. LN 23 stated there was no urinary catheter care order for Resident 12. LN 23 stated the wound care nurse (WCN) was responsible for providing the catheter care to the residents with catheter. LN 23 further stated, I don't know how to do that foley (urinary catheter) care.</p> <p>On 3/26/25 at 2:20 P.M., an interview was conducted with the wound care nurse (WCN). The WCN stated the LNs who passed medications were responsible in providing catheter care to residents with urinary catheter.</p> <p>On 3/26/25 at 3:24 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for the residents with urinary catheter was, the nurses should have verified the residents' physician for urinary catheter care order. The DON stated there should be a documentation that catheter care was provided to residents with urinary catheter to prevent infection. The DON stated the expectation was the LNs were responsible to clean the insertion site.</p> <p>A review of the facility's policy, titled Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections .Perineal care, 1. Use soap and water or bathing wipes for routine daily hygiene .Documentation, The following information should be recorded in the resident's medical record, 1. The date and time that catheter care was given .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610</p> <p>Based on observation, interview, and record review the facility failed to ensure oxygen (O2) was administered per physician's order for one of three sampled residents (Resident 19) reviewed for O2 therapy.</p> <p>This failure had the potential to affect Resident 11's respiratory health.</p> <p>Findings:</p> <p>A review of Resident 19's Admission Record indicated Resident 19 was readmitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD, respiratory illness that limits airflow into and out of the lungs).</p> <p>A review of Resident 19's history and physical (H &P) dated 6/19/24 was conducted. Resident 19's attending physician documented Resident 19 had severe COPD and required to continue O2 therapy. Per the H&P, Resident 19 had history of cognitive impairment.</p> <p>A review of Resident 19's physician order dated 2/14/25 indicated the following order: Continuous O2 at 2 liters per minute (LPM) via nasal cannula (NC, a tubing that delivers O2 connected to the O2 tank or O2 concentrator through the resident's nose).</p> <p>During an observation and an interview of Resident 19 in her room, on 3/24/25 at 10:45 A.M., Resident 19 laid in bed, with O2 at 4 LPM/ NC connected to the O2 concentrator. Resident 19 stated she was fine.</p> <p>During an observation and an interview of Resident 19 in her room on 3/25/25 at 3:52 P.M., Resident 19 laid in her right side, with O2 at 4 LPM/ NC connected to the O2 concentrator. Resident 19 did not respond when her name was called.</p> <p>During an interview with Certified Nursing Assistant (CNA) 22 on 3/26/25 at 10:10 A.M., CNA 22 stated Resident 19 had her O2 therapy all the time and the Licensed Nurses (LNs) were responsible for Resident 19's O2 therapy.</p> <p>During a record review of Resident 19's clinical record, a photo taken of O2 administered to Resident 19, and an interview with LN 21 on 3/26/25 at 11:57 A.M., LN 21 stated Resident 19 had a physician order that indicated Resident 19's O2 therapy was at 2 LPM/NC. LN 21 stated the LNs were supposed to follow the physician's order to make sure Resident 19 would not develop O2 toxicity (lung damage that happens from breathing in too much extra [supplemental] oxygen, also called O2 poisoning).</p> <p>During an interview with the Director of Nursing (DON) on 3/26/25 at 3:24 P.M., the DON stated LNs should have followed the physician order to prevent Resident 19 from developing O2 toxicity.</p> <p>A review of the facility's policy titled, Medication and Treatment Orders, revised 7/2016, indicated, Orders for medications and treatments will be consistent with principles of safe and effective order .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled, Oxygen Administration, revised 10/2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration .Review the physician's order .for oxygen administration .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270</p> <p>Based on observation, interview, and record review, the facility failed to ensure an inhaler was labeled after it was opened and used for one resident (300).</p> <p>This failure had the potential for the resident to receive an ineffective medication.</p> <p>Findings:</p> <p>Per the facility's admission record, Resident 300 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (chronic lung disease).</p> <p>A review of Resident 300's medication orders indicated on 3/5/2025, the physician ordered, Fluticasone Furoate Vilanterol Inhalation (medication used to treat respiratory disease) - 1 puff inhale orally one time a day for shortness of breath (SOB)/wheezing .</p> <p>On 3/27/25 at 9:49 A.M., a joint observation and interview was conducted with LN 11 of the medication (med) cart. In the med cart, an opened box of Fluticasone furoate inhaler was found with no open date. LN 1 stated she opened the box yesterday and forgot to label it. LN 1 stated it should have been labeled with the opened date.</p> <p>On 3/27/25 at 2:30 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was their expectation that all opened multidose medications need to be dated with the opened date.</p> <p>A review of the facility's policy titled, Medication Labeling and Storage, dated 2001, indicated, The facility stores all medications .5. Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45909</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary measures were met in the kitchen during dietary operations, according to standards of practice when:</p> <ol style="list-style-type: none"> 1. One outdated container of sour cream was not discarded and still stored for use and consumption. 2. Personal clothing items that belonged to staff were hanging on the food container carts. <p>These failures had the potential to expose residents to unsafe and unsanitary food practices that could lead to widespread foodborne illnesses.</p> <p>Findings:</p> <p>1. On 3/24/25 at 8:19 A.M., a concurrent observation and interview was conducted with the Certified Dietary Manager (CDM). One container of sour cream was labeled with a use by date (when food should be consumed) of 3/22/25. The CDM stated the sour cream container should have been thrown away on or before the use by date to prevent residents from developing any foodborne illness if they consumed food items past the use by date.</p> <p>On 3/25/25 at 10:01 A.M., an interview was conducted with the Registered Dietitian (RD). The RD acknowledged that the sour cream container should have been discarded per label, to avoid using outdated food items.</p> <p>A review of the Food and Drug Administration (FDA; United States (US) government agency that ensures safety of food) 2022 indicated 3-501.18 Ready to Eat, Disposition (A) A food shall be discarded if it . (3) Is inappropriately marked with a date or exceeds a temperature and time</p> <p>2. On 3/24/25 at 8:28 A.M., a concurrent observation and interview was conducted with the Certified Dietary Manager (CDM). Personal clothing items were observed hanging on the food storage container carts. The CDM stated that personal clothes should have been kept inside the lockers to maintain food safety in the kitchen.</p> <p>An interview was conducted with the Registered Dietitian (RD) on 3/25/25 at 10:07 A.M. The RD acknowledged that all kitchen staff's personal belongings should be kept away from food items and equipment.</p> <p>The facility's policy titled Employee Personal Items dated 2023, indicated, Policy: Personal items brought in by staff from outside will not be kept in the kitchen.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270</p> <p>Based on observation, interview, and record review, the facility failed to provide proper resident cohorting (the grouping of individuals with the same condition in the same location) for one resident (298) when Resident 298 was admitted into a room that was on isolation transmission-based precautions related to Resident 54's exposure to Influenza A (flu-respiratory infectious disease).</p> <p>This failure had the potential for Resident 298 to be exposed to an infectious disease.</p> <p>Findings:</p> <p>Per the facility's admission record, Resident 54 was admitted on [DATE] with diagnoses that included a left femur (the long bone located in the thigh) fracture.</p> <p>Per the facility's admission records, Resident 298 was admitted on [DATE] with diagnoses that included mild intermittent asthma (a respiratory disease).</p> <p>On 3/24/25 at 8:36 A.M., an observation was conducted of room [ROOM NUMBER] with a with a signage posted outside of the room isolation contact precautions.</p> <p>On 3/24/25 at 9:25 A.M., an interview and record review were conducted with LN 13. LN 13 stated Patient 54 was placed on isolation precautions due to exposure of Influenza A on 3/21/25. LN 13 stated on 3/22/25, Resident 298 was admitted into the isolation precaution room on 3/22/25.</p> <p>On 3/26/25 at 2:30 P.M., an interview was conducted with the Infection Preventionist Nurse (IPN). The IPN stated that Resident 54 should not have been admitted into the same room as Resident 298. The IPN stated Resident 298 was tested for Influenza A, but the results were still pending.</p> <p>On 3/27/25 at 2:20 P.M., an interview was conducted with the Director of Nursing. The DON stated resident 54 should not have been admitted into the same room as Resident 298. The DON stated it was her expectation that room cohorting of type of contact precautions need to be coordinated by the staff to ensure residents are not exposed to infectious diseases.</p> <p>A review of the facility policy titled Influenza, Prevention and Control of Seasonal, dated 2001, indicated 1. The prevention of seasonal influenza outbreaks is a coordinated effort .</p>		