STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055632	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grossmont Post Acute Care	8787 Center Drive LA Mesa, CA 91942

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a peripherally inserted central catheter (PICC, a long, thin and flexible tube [catheter] that is inserted into a vein in the upper arm for medication administration) was measured weekly for one of two residents reviewed (Resident 1).This failure resulted in Resident 1 returning to the hospital with chest pain, removal of the PICC, and replacement with another catheter to complete medication administration. Findings:A consumer complaint was filed with the California Department of Public Health regarding Resident 1's catheter. The complaint alleged the catheter had moved out of the original position and posed a risk to Resident 1's health.According to an undated Face Sheet, Resident 1 was admitted to the facility on [DATE] with diagnoses to include an infection in the bone.An interview was conducted with Licensed Nurse (LN) 1 on 5/14/26 at 2:30 P.M. LN 1 stated a PICC line was for intravenous (IV, within a vein) medications, and only a Registered Nurse (RN) could administer those to residents. LN 1 stated her role was to monitor the PICC line site on the resident's arm for any signs and symptoms of infection or swelling, and if they observed any of those, they would inform the RN. LN 1 stated other than monitoring the site, the RNs would manage the PICC line. An interview was conducted with RN 1 on 5/14/26 at 2:40 P.M. RN 1 stated she was responsible for administering medications through the PICC line for all residents. RN 1 stated when administering medications, she looked for bleeding, redness or swelling, which could mean the IV was not positioned correctly. RN 1 stated a clear dressing (a protective device to hold the IV in place and prevent bacteria from getting into the vein) which covered the IV was changed every Sunday. RN 1 stated when the dressing was changed, the RN measured the arm circumference and the length of the catheter. RN 1 stated both of those measurements were important to ensure the resident did not have an infection from the catheter, and to ensure the catheter was always in the same position in the vein. RN 1 stated she did not work Sundays, so she did not routinely change the dressings for residents with PICC lines. An interview and record review was conducted with RN 2 on 5/14/26 at 3:15 P.M. RN 2 stated she did work on Sundays, and she was familiar with the process for changing the dressings on PICC lines. RN 2 was able to describe the process, and stated measurements of arm circumference and catheter length were important to ensure the resident was receiving the medication safely. RN 2 stated the PICC line dressing kit used to change the dressing on Sundays included a measuring tape. RN 2 reviewed Resident 1's IV Medication Administration Record (MAR), and stated, There are no measurements. The RN should have documented the catheter length and the arm circumference so they could compare those values to the previous week. If there wasn't a place in the IV MAR, the RN could have written a progress note, but I don't see one.A record review was conducted.A physician's order, dated 4/13/26, indicated Resident 1 was to receive an antibiotic twice daily for a bone infection. A physician's order, dated 4/13/26, indicated the RN was to change the dressing and securement device (a clip to hold the PICC line in place) every Sunday, and to measure the catheter length and the arm circumference in centimeters after each dressing change. The IV MARs for April and May 2026 were reviewed. No measurements of catheter length or arm circumference were identified. According to the MAR, the PICC line dressing was changed on 4/19/26, 4/26/26, and 5/3/26. An interview and (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent record review of Resident 1's IV orders and MAR was conducted with the Director of Nursing (DON) on 5/14/26 at 4:30 P.M. The DON stated it was the responsibility of the RN who admitted the resident to obtain the measurements from the hospital when a resident was admitted to the facility. The DON stated if the measurements were not available, the RN should measure on the day the resident arrived so the facility would have a baseline to compare to the Sunday measurements. The DON reviewed Resident 1's record and stated there was no measurements on admission, or from the Sunday dressing changes. Per the DON, this could cause a complication such as an infection, and the RN would be unable to compare to previous measurements to ensure the catheter was still in place. The DON stated the RN should have documented the measurements, but did not. Per the facility policy, updated January 2021 and titled PICC Dressing Change, .The PICC catheter insertion site is a potential entry site for bacteria that could produce a catheter-related infection. Documentation: Document date and time of procedure, site assessment, length of external catheter.