

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Mission Skilled Nursing & Subacute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 410 North Winchester Boulevard Santa Clara, CA 95050	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686</p> <p>Based on interview and record review, one of two sampled residents (Resident 1) was not free from physical abuse when Resident 1 was found in bed with multiple bruises to the face and arms, swelling on the bridge of the nose and right eyebrow, a cut on the lower lip, blood in the mouth, on the lips, and on the fingers, and chipped teeth. Resident 1 passed away, and the immediate cause of death was documented as, Blunt force injury [injury caused by forceful impact from an object without sharp edges or points] of head complicating hypertensive [having high blood pressure] and atherosclerotic cardiovascular disease [heart disease involving plaque buildup in the arteries].</p> <p>Findings:</p> <p>Review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually caused by infection), chronic obstructive pulmonary disease (COPD, a disease that causes obstructed airflow from the lungs), severe protein-calorie malnutrition (significant fat loss and muscle wasting), muscle weakness, paroxysmal atrial fibrillation (a type of irregular heart rate), stage 4 pressure ulcer (an injury resulting from prolonged pressure that involves full thickness tissue loss with exposed bone, tendon or muscle), congestive heart failure (a condition in which the heart cannot pump blood well enough to provide a normal supply to the body), osteoporosis (a condition that causes the bones to become brittle and fragile), and osteoarthritis (degeneration of the joints that causes pain and stiffness).</p> <p>Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated [DATE], indicated Resident 1 had a brief interview for mental status (BIMS) score of 3 (a score of 0 to 7 indicates severe cognitive impairment [problems with how a person thinks, learn, use judgment and make decisions]). The MDS indicated Resident 1 required substantial/maximal assistance (staff does more than half the effort) for rolling left and right in bed. The MDS also indicated Resident 1 was dependent (staff does all of the effort) for moving from a lying to sitting position in bed and moving from a sitting to lying position in bed. The MDS further indicated Resident 1 refused to move from a sitting to standing position and refused to transfer to and from her bed to a chair or wheelchair.</p> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a tool used to communicate information to the resident's doctor), dated [DATE], indicated Resident 1 was involved in an incident of alleged physical abuse. The SBAR indicated, Found bruises on the resident's nose bridge, left and right cheek, left forehead, and chin. Also noted that the resident's front upper teeth were chipped and there is dried blood on the lower lip. There is also swelling on the bridge of the nose. The SBAR also indicated Resident 1 had, extensive bruising on face and arms. Blood in mouth and on lips and fingers. The SBAR also indicated Resident 1 has bruising on the right side of the face, bruising on the lips, swelling on the right eyebrow area. The SBAR further indicated, The resident has a multiple discoloration and swelling on her face, chipped upper front teeth and cut on the lower lip.</p> <p>During an interview with certified nursing assistant (CNA) A on [DATE], at 2:13 p.m., CNA A stated when she started work at 3:00 p.m. on [DATE], Resident 1 was in bed sleeping. CNA A stated she later provided care to Resident 1 at 6:30 p.m., at which time the resident did not have any injuries. CNA A stated the next time she saw Resident 1, at around 8:30 p.m. or 9:30 p.m., she saw bruises on Resident 1's face and blood on Resident 1's lips. CNA A stated she did not know of anyone who saw what happened to Resident 1. She stated Resident 1 was not able to get out of bed, and Resident 1 did not have any behaviors of self-harm.</p> <p>During an interview with registered nurse (RN) B on [DATE], at 3:17 p.m., RN B stated on [DATE], she and RN C were informed by RN D that Resident 1 had injuries to her face. RN B stated when staff asked Resident 1 what happened, the resident stated she did not know. RN B stated Resident 1 did not have behaviors of self-harm, and it was unlikely that Resident 1 inflicted the injuries on herself. RN B stated staff had determined Resident 1 did not fall out of bed, as the resident was dependent with care and would not have been able to get up and get herself back into bed after a fall.</p> <p>During an interview with RN C on [DATE], at 3:32 p.m., RN C stated on [DATE], at around 9:45 p.m., she was notified of Resident 1's injuries. RN C stated she went to the resident's room and saw Resident 1 in bed with bruises and swelling on her face, chipped teeth, and a cut on the inside of her lower lip. RN C stated Resident 1 did not remember what happened. RN C stated it was not likely that Resident 1 fell and got herself back into bed.</p> <p>During an interview with RN D on [DATE], at 3:49 p.m., RN D stated on [DATE], she initially saw Resident 1 at around 3:00 p.m. or 4:00 p.m., and Resident 1 did not have injuries at that time. RN D stated she gave medications to Resident 1 between 5:30 p.m. and 6:00 p.m. and the resident still had no injuries. RN D stated CNA A informed her of Resident 1's injuries at around 9:30 p.m. RN D stated she went into Resident 1's room and saw bruising and swelling on Resident 1's face, a chipped tooth, and a cut with dried blood on her lip. RN D stated she did not think Resident 1 would have been able to get herself back into bed if she fell. She also stated she did not think Resident 1 caused the injuries herself, as Resident 1 did not have behaviors of hitting or harming herself.</p> <p>Review of the facility's undated investigation summary indicated that on [DATE], CNA A went into Resident 1's room and noted Resident 1 had, multiple bruises and swelling on her face, chipped front teeth and cut on lower lip. The investigation summary further indicated Resident 1 was sent to the acute hospital for further evaluation.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Resident 1's Emergency Department Attending Physician Note, dated [DATE], indicated Resident 1 was brought in by ambulance after Resident 1 was assaulted at her nursing facility. The note indicated, Yesterday evening patient was assaulted between the hours of 9 and 11. The note further indicated, Patient is more altered than normal today. She has not been talking at all today and usually she can have a conversation. She has bruising to the right side of her face and a chipped tooth.</p> <p>Review of Resident 1's Medicine History and Physical from the acute hospital, dated [DATE], indicated, Noted abrasions on left side of face, bruising around the lips with chipped tooth. The Medicine History and Physical indicated diagnostic imaging showed Resident 1 had, Mild right malar soft tissue swelling [mild swelling in the right facial cheek area].</p> <p>Review of Resident 1's Physician Discharge Summary from the acute hospital, dated [DATE], indicated Resident 1 was declared deceased (dead) at 4:06 p.m. The Physician Discharge Summary further indicated Resident 1's family requested an autopsy (examination to determine the cause of death) and the coroner (an official who investigates violent, sudden, or suspicious deaths) was notified.</p> <p>Resident 1's Certificate of Death, issued [DATE], was reviewed. The first page of the certificate indicated Resident 1's immediate cause of death was Pending. The second page of the certificate contained a Physician/Coroner's Amendment that indicated Resident 1's immediate cause of death was, Blunt force injury of head complicating hypertensive and atherosclerotic cardiovascular disease. The Physician/Coroner's Amendment indicated Resident 1's injury occurred on [DATE] at [facility address] and indicated, Bedbound subject found in bed with facial trauma in a shared room at a skilled nursing facility. The Physician/Coroner's Amendment further indicated Resident 1's manner of death was, Homicide [the killing of one person by another].</p> <p>The facility's policy titled Alleged or Suspected Abuse and Crime Reporting, revised ,d+[DATE], indicated each resident has the right to be free from abuse.</p>		