

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055954	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/16/2026
NAME OF PROVIDER OR SUPPLIER  National City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  220 East 24th Street National City, CA 91950	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to notify the California Long-Term Care Ombudsman Program (advocacy for skilled nursing facility residents) of emergent hospital transfers and the facility failed to notify and obtain confirmation from residents within 24 hours regarding their bed hold policy, for two of 16 sampled residents (Resident 1 and Resident 2)These deficient practices placed two residents at risk for loss of their bed hold rights, lack of advocacy (the act of speaking up) support, and potential inappropriate discharge or inability to return to the facility.Findings:1. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated [DATE] indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On [DATE] at 2:30 P.M., an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated Resident 1 was sent to the hospital during their break ([DATE] at 4PM), at which time emergency medical services had already arrived and transported Resident 1 to the hospital.On [DATE] at 3:09 P.M., a concurrent interview and record review was conducted with LN 2. LN 2 stated he identified a change in Resident 1's condition on [DATE] at approximately 11 P.M., when Resident 1 complained of shortness of breath, and initiated a change in condition report, obtained orders for a breathing treatment and a STAT (without delay) chest X-Ray (painless test that uses safe amounts of electromagnetic radiation to take pictures of the inside of your body). LN 2 stated that despite interventions, Resident 1's condition declined, and at approximately 4 A.M., on [DATE], Resident 1 continued to experience shortness of breath and requested to be sent to the hospital. LN 2 stated he notified the physician, left a message and proceeded with sending Resident 1 to the hospital via emergency services due to worsening respiratory status and ineffective breathing treatment. During a review of Resident 1's medical record on [DATE], Resident 1's Bed Hold 24-hour notification section was not signed and Resident 1's record lacked documentation of a Notice of Transfer Notification to the ombudsman (resident advocate that helps with resident concerns), as no evidence of such notification was found in the requested records.On [DATE] at 4:49 P.M., an interview was conducted with the Medical Records Director (MRD). The MRD stated the former Social Services Director (SSD) was responsible for completing and sending discharge and transfer notifications, including notification to the ombudsman. The MRD confirmed bed hold forms completed upon admission; however unexpected hospital transfers, medical records were responsible for completing and faxing the Notice of Transfer to the ombudsman. The MRD acknowledged this process was not completed for Resident 1. The MRD further stated ombudsman notification was necessary to ensure resident advocacy and support during transfers and appeals, indicating a failure in the facility's process to ensure required notifications were completed.On [DATE] at 5:02 P.M., an interview was conducted with the SSD. The SSD stated (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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the Social Services Department provided discharge notifications in advance of planned discharges and obtained fax confirmation; however, for unplanned hospital transfers, the Medical Records Department was responsible for notifying the ombudsman. The SSD confirmed the ombudsman served as an advocate for residents during transfers, including assisting with concerns, and appeals. The SSD further stated the nursing staff was responsible for notifying residents and/or responsible parties for the 24-hour bed hold policy to ensure residents understood their right to return to the facility, including the duration and financial terms of the bed hold. The SSD's statements confirmed the facility failed to ensure timely ombudsman notification and resident notification of bed hold rights for unplanned transfers. On [DATE] at 5:15 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated, the facility's expectation was to provide bed hold information to residents on the day of transfer and to ensure notification of transfer was faxed to the ombudsman by the MRD and SSD for planned discharges. The DON confirmed residents were to be informed of their right to return to the facility, including the duration of the bed hold and associated payment requirements once the bed hold period expired. The DON further acknowledged the importance of notifying the ombudsman was to ensure resident advocacy and support during transfers and appeals, and stated the facility was implementing changes to its discharge and notification process, indicating prior failures in ensuring required notifications were completed. A review of the facility's policy and procedure titled Transfer or Discharge dated 2001, indicated . That an appropriate notice was provided to the resident and/or legal representative . 2. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A record review of Resident 2's Minimum Data Set (MDS- nursing facility assessment tool) dated [DATE] indicated that Resident 2 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. On [DATE] at 12:06 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 2 experienced a change in condition on [DATE] for hypoxia (low oxygen levels) and notified Resident 2's Physician (MD) along with Resident 2's conservator LN 1 stated Resident 1 had not exhibited episodes of hypoxia prior to being transferred. LN 2 stated Resident 2 was assessed by the Nurse Practitioner on [DATE] who had ordered labs then was later transferred to the hospital on [DATE] due to hypoxia. During a review of Resident s's medical record on [DATE], Resident 1's record lacked documentation of for a Bed Hold and Notice of Transfer Notification to the ombudsman (resident advocate that helps with resident concerns). No evidence of such notification was found in the requested records. On [DATE] at 4:49 P.M., an interview was conducted with the Medical Records Director (MRD). The MRD stated the former Social Services Director (SSD) was responsible for completing and sending discharge and transfer notifications, including notification to the ombudsman. The MRD confirmed bed hold forms were completed upon admission; however unexpected hospital transfers, the Medical Records Department was responsible for completing and faxing the Notice of Transfer to the ombudsman. The MRD acknowledged this process was not completed for Resident 1 and confirmed the ombudsman was notified of Resident 2's transfers to the hospital. The MRD further stated ombudsman notification was necessary to ensure resident advocacy and support during transfers and appeals. On [DATE] at 5:02 P.M., an interview was conducted with the SSD. The SSD stated the Social Services Department provided discharge notifications in advance of planned discharges and obtained fax confirmation; however, for unplanned hospital transfers, the Medical Records Department was responsible for notifying the ombudsman. The SSD confirmed the ombudsman served as an advocate for residents during transfers, including assisting with concerns, and appeals. The SSD further stated the nursing staff was responsible for notifying residents and/or responsible parties for the 24-hour bed hold policy to ensure residents understood their right to return to the facility, including the duration and financial terms of the bed (continued on next page)</p>		

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