

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/22/2026
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)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care 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 provide respiratory care services (professional services for residents with breathing problems) in accordance with professional standards of practice for two of 10 residents reviewed for oxygen use when: Resident 1's oxygen equipment was not set up correctly by a licensed healthcare provider, and Resident 2's humidifier (water attached to oxygen machine to provide moisture to the delivered oxygen) was empty. This failure had the potential to further compromise the respiratory status of the residents. Findings: A consumer complaint was received by the California Department of Public Health (CDPH) alleging the facility was not monitoring oxygen equipment adequately for residents. The complaint alleged that the equipment had been observed to be incorrectly set up, resulting in oxygen not being delivered as ordered by the physician. 1. Resident 1 was readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a lung disease that causes difficulty breathing) and chronic respiratory failure with hypoxia (a long-term breathing problem where lungs cannot maintain adequate oxygen levels), per the undated admission Record. A record review was conducted. According to Resident 1's physician's orders, dated 5/7/26, Resident 1 was to receive oxygen at three liters per minute (LPM) at all times. The order indicated the oxygen could be adjusted between two and five LPM to maintain Resident 1's oxygen level between 88-92% due to her history of COPD and respiratory failure with hypoxia. According to a Respiratory Therapist (RT, a specialized professional who treats patients with breathing problems) note, dated 6/5/26, an RT was made aware of an equipment malfunction for Resident 1. The RT documented that a nurse from an outside agency had brought the concerns to her attention, and she had informed the nurse that Resident 1 often refused to wear the equipment, which was more likely the cause of any problems. The RT documented that the equipment was monitored daily for any problems. An observation of Resident 1 was conducted on 6/22/26 at 12:02 P.M. in the facility dining room. Resident 1 was seated at a table in a wheelchair. Resident 1 had a nasal cannula (NC, a hollow tube which delivered oxygen from a tank or concentrator). The NC was connected to a white concentrator which was strapped to the back of the wheelchair. The concentrator display was on, and indicated Resident 1 was receiving three liters of oxygen per minute (LPM), and that the concentrator had approximately 12% of its power storage left. The display showed a low battery indicator. The NC was coiled behind Resident 1's back as she sat back against the wheelchair. An interview was conducted with Resident 1 on 6/22/26 at 12:04 P.M. Resident 1 stated she did not feel as if she were getting enough oxygen through the NC. An observation of Resident 1 was conducted on 6/22/26 at 12:08 P.M. Resident 1's NC was connected to a green oxygen tank strapped to the back of the wheelchair. The green oxygen tank gauge was set to four LPM. The NC tubing remained compressed behind Resident 1's back. Licensed Nurse (LN) 1 approached and sked Resident 1 how she felt, and Resident 1 repeated that she felt she was not receiving enough oxygen. LN 1 tested Resident 1's oxygen level using a pulse oximeter (PO, a device that measured oxygen levels in the bloodstream). The PO measured Resident 1's oxygen level as 89% (with a normal range of 95-100%). LN 1 asked Resident 1 to take deep breaths, and Resident 1 complied. LN 1 checked the NC and removed it from behind Resident 1's back, and then rechecked the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055954
		If continuation sheet Page 1 of 3

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PO. Resident 1's oxygen level rose to 90%. Resident 1 stated she felt better and was getting more oxygen. An interview was conducted with LN 1 on 6/22/26 at 12:15 P.M. LN 1 stated she could not explain why the NC was switched from the white concentrator to the green oxygen tank. LN 1 stated staff should have checked that the concentrator was adequately charged before bringing Resident 1 to the dining room. LN 1 stated only nurses or respiratory therapists (RT) could apply oxygen to residents. LN 1 stated there was no LN or RT in the dining room. An interview was conducted with LN 2 on 6/22/26 at 12:38 P.M. LN 2 stated he was assigned to Resident 1 that day. LN 2 stated if a resident required oxygen, the nurse was responsible for setting the oxygen concentrator or tank on the correct settings based on the physician's order. LN 2 stated nobody has asked him to set up the oxygen for Resident 1. LN 2 stated he had not gone to the dining room and switched Resident 1's NC from the concentrator to the oxygen tank. An interview was conducted with Certified Nursing Assistant (CNA) 1 on 6/22/26 at 12:40 P.M. CNA 1 stated she was familiar with Resident 1's care and was assigned to her that day. CNA 1 stated she had assisted Resident 1 in moving from her bed to the wheelchair, then connected the NC to the white concentrator. CNA 1 stated when she placed the NC on Resident 1, she tested the oxygen on her arm and was able to feel it on her skin. CNA 1 stated she then wheeled Resident 1 to the dining room. CNA 1 stated she was not allowed to adjust the oxygen levels on the tank, that only a nurse or RT could do so. CNA 1 stated the white oxygen concentrator had a low battery, and the 12% remaining power would not be enough to last Resident 1 through lunch. CNA 1 stated she did not switch the NC from the white concentrator to the green oxygen tank. An interview was conducted with RT 1 on 6/22/26 at 1:07 P.M. RT 1 stated she and another RT were in the facility full time. RT 1 stated there were usually two RTs to monitor residents with respiratory issues. RT 1 stated she had switched Resident 1's NC from the white concentrator to the green oxygen tank. RT 1 stated she had noticed the low battery indicator and switched the NC. RT 1 stated she was not aware of a concern with Resident 1's oxygen from the consumer complaint, but that Resident 1 was known to refuse to use oxygen on occasion. RT 1 stated monitoring of oxygen equipment for all residents was a shared responsibility of nursing, RT and CNAs. RT 1 stated only nurses and RTs were allowed to apply the NC or make changes to the oxygen settings. An interview was conducted with CNA 2 on 6/22/26 at 1:38 P.M. CNA 2 stated a CNA could apply the NC for the residents and turn on and off the oxygen concentrator. CNA 2 stated if she did not know the correct oxygen setting, she could assume it was two LPM, as that was the setting most of the residents were on. CNA 2 stated she could ask the nurse to confirm if needed. CNA 2 stated she was allowed to start or stop the oxygen supply to the residents. An interview was conducted with LN 3 on 6/22/26 at 1:43 P.M. LN 3 stated nurses or RT were the only professionals who were allowed to start and stop oxygen supplied to the residents. LN 3 stated CNAs were not supposed to set up oxygen, as oxygen was considered a medication and as such, only nurses or RT could apply it for residents. LN 3 stated it was the responsibility of the nurse or RT to check that the oxygen equipment was working correctly and set up properly as it was vitally important for the resident's health. An interview was conducted with the Director of Staff Development (DSD, a professional who oversees the training and supervision of CNAs) on 6/22/26 at 2:15 P.M. The DSD stated CNAs should not be changing oxygen tubing or turning the machine on or off. The DSD stated that training had been done when the facility added RTs but she did not recall if the training outlined the role of CNAs. An interview was conducted with the Administrator (Admin) on 6/22/26 at 4 P.M. The Admin stated only LNs could initiate or adjust oxygen. The Admin stated the CNAs could transfer residents from the bed to a chair, but that the nurse or RT would apply the oxygen, and adjust or change the oxygen concentrator. The Admin stated RT provided clinical oversight of residents on oxygen therapy. The Admin stated she had not been informed of the consumer complaint regarding Resident 1's oxygen equipment being set up improperly. A policy or procedure was requested outlining staff responsibilities for oxygen use but was not provided by the facility. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses to include COPD, per the undated admission Record. A record review was conducted. According to (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's physician's orders, dated 5/11/26, Resident 2 was to receive oxygen at two LPM as needed, with a humidifier when oxygen was delivered at four LPM or higher. A concurrent interview and observation with Resident 2 was conducted on 6/22/26 at 11:30 A.M. Resident 2 was in bed, with a NC in place. Resident 2 stated she always used oxygen. Resident 2 stated she had once had dry nostrils from the oxygen, and it caused a nose bleed to occur. Resident 2 stated from that time on, she wanted the humidifier on the oxygen concentrator so her nostrils stayed moist and a nose bleed would not reoccur. The humidifier was observed to be empty, with several droplets of water in the NC tubing. The date written on the humidifier was 6/16/26. An interview and observation of Resident 2 was conducted with the DSD on 6/22/26 at 4 P.M. The DSD observed the empty humidifier bottle on the oxygen concentrator and stated the bottle should have been replaced by a nurse or RT prior to becoming empty. The DSD stated if the resident requested the humidifier, the nurse should have informed the physician so the order for oxygen therapy could be changed. An interview and record review was conducted with LN 3 on 6/22/26 at 4:20 P.M. LN 3 stated the oxygen set up should match the physician's order. LN 3 stated using the humidifier for Resident 2 while on two LPM of oxygen was not what was ordered by the physician. LN 3 stated if there was a discrepancy between the oxygen therapy provided and the physician's order, staff should contact the physician to clarify and change the order. According to a facility policy, dated 1/31/23 and titled Oxygen Administration, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		