

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Mission Hills Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3680 Reynard Way San Diego, CA 92103	

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 - Some</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** 46235</p> <p>Based on observation, interview and record review, the facility failed to provide respiratory care services for three residents (Resident 5, 6 and 7) who used CPAP machines (continuous positive airway pressure-a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) when:</p> <ol style="list-style-type: none"> 1. There was no ongoing assessment to evaluate resident's respiratory status and response to the use of the CPAP machine. (Resident 5 and Resident 6) 2. The medication administration record was signed when Resident 5's CPAP was not available. In addition, Resident 5's medical record did not indicate staff follow up of Resident 5's CPAP according to physician's order. 3. Resident 7 used a CPAP machine but did not have a physician's order. <p>These failures had the potential for residents to receive inappropriate care and treatment to address their respiratory problems.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 5 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. <p>Resident 5's BIMS (Brief Interview of Mental Status) score was 15, cognitively intact according to the Minimum Data Set (MDS- a clinical assessment tool) dated 3/29/24.</p> <p>During an observation and interview on 4/4/24 at 9:42 A.M., Resident 5 was sitting at the edge of her bed with a CPAP machine on top of the bedside drawer. Resident 5 stated it was the first-time last night on 4/3/24 that she used the CPAP. Resident 5 stated she applied the CPAP mask and turned on the machine by herself at bedtime. Resident 5 stated she also removed the CPAP mask and turned off the machine in the morning. Resident 5 showed the machine's water chamber, and it was empty. Resident 5 stated it was empty when she turned on the machine at night and needed to ask the staff if the facility had distilled (a type of purified water) water. Resident 5 further stated nobody from the facility had checked the machine or if she had applied it or not since the CPAP was brought in by a friend.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 6 was admitted to the facility on [DATE] according to the facility's Admission Record.</p> <p>During a review of the nurse practitioner's (NP) progress note dated 3/1/24, the PN indicated Resident 6 had diagnoses including OSA and was using a CPAP machine. The NP progress note further indicated Resident 6 was, Oriented to person, place, time, and surroundings.</p> <p>An observation and interview on 4/4/24 at 9:58 A.M. with Resident 6 was conducted. Resident 6 was sitting up in a wheelchair in her room with a CPAP machine on top of a bedside drawer. The CPAP machine was connected to tubing with a nasal mask (a mask that fits in the nose) on top of Resident 6's bed. Resident 6 stated she owned the CPAP machine, and she applied the nasal mask on herself at bedtime and removed it in the morning. Resident 6 pointed at a bottled water at bedside and stated she filled the CPAP's water chamber when it was low. Resident 6 stated the facility staff did not check if she applied the CPAP or checked the machine. Resident 6 further stated she fixed the machine once when there was something wrong with the machine.</p> <p>2. During a review of Resident 5's medication administration record (MAR) for CPAP use dated March 2024, the MAR indicated check marks on: 3/17/24, 3/18/24, 3/23/24, 3/30/24 and 3/31/24. The MAR indicated a 7 on 3/16/24, 3/9/24, 3/21/24, 3/22/24, 3/24/24 through 3/29/24.</p> <p>During a review of Resident 5's medication administration record (MAR) for CPAP use dated April 2024, the MAR indicated a 7 for 4/1/24 and check marks for 4/2/24 and 4/3/24.</p> <p>An interview and concurrent record review was conducted with the assistant director of nursing (ADON) on 4/4/24 at 11:35 A.M. The ADON indicated check marks on the MAR indicated the medication was administered and a 7 indicated to see nurse's notes. The ADON stated a nursing progress note dated 4/1/24 at 11:08 P.M. indicated the CPAP had a missing piece and on 4/2/24 the NP progress note indicated Resident 5's friend brought in CPAP, and it needed a part from home. The ADON stated there were inconsistencies in Resident 5's medical record whether the CPAP was available or not. The ADON further stated staff should have followed up with the CPAP's missing part.</p> <p>3. Resident 7 was admitted to the facility on [DATE] with diagnoses including OSA according to the facility's Admission Record. The Admission Record indicated Resident 7 was discharged on [DATE].</p> <p>During a review of Resident 7's progress notes (PN) dated 2/6/24 at 5:23 A.M., the PN indicated, Resident was observed in bed with c-pap in place.</p> <p>A review of Resident 7's physician orders for the month of February 2024, the physician's orders did not indicate an order for CPAP.</p> <p>An interview with the assistant director of nursing (ADON) was conducted on 4/4/24 at 11:51 A.M. The ADON stated there should be a physician's order for the use of CPAP. The ADON stated staff should also document any follow up needed to address CPAP problems and only sign the MAR if CPAP was administered. The ADON stated the licensed nurse should also monitor how the resident tolerated the use of CPAP. The ADON further stated these were important because the CPAP affected the resident's breathing.</p> <p>(continued on next page)</p>		

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<p>F 0695</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 undated policy and procedure (P&P) titled, CPAP-BiPAP Monitoring and Management was conducted. The P&P indicated, .CPAP devices be administered as ordered by the physician .for machines using humidification, fill appropriate chamber with distilled water .Physician will be notified immediately of any concern .Re-assess the patient as needed in response to changes in physician orders, changes in patient condition .</p> <p>The policy did not provide guidance for staff regarding ongoing assessment of residents using a CPAP machine.</p>		

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<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** 46235</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control standards of practice when respiratory equipment were not stored appropriately for two residents (Resident 5 and Resident 6).</p> <p>This failure had the potential for residents to acquire an infection.</p> <p>Resident 5 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record.</p> <p>During an observation and interview on 4/4/24 at 9:42 A.M., Resident 5 was sitting at the edge of her bed with a CPAP machine on top of the bedside drawer. The CPAP machine was connected to a tubing and mask exposed on top of the machine. Resident 5 further stated nobody from the facility had checked the machine or if she had applied it or not. A small oxygen tank was also observed at Resident 5's bedside with an oxygen tubing hanging on the tank. The tubing did not have a date.</p> <p>Resident 6 was admitted to the facility on [DATE] according to the facility's Admission Record.</p> <p>During a review of the nurse practitioner's (NP) progress note dated 3/1/24, the PN indicated Resident 6 had diagnoses including OSA and was using a CPAP machine.</p> <p>An observation and interview on 4/4/24 at 9:58 A.M. with Resident 6 were conducted. Resident 6 was sitting up in a wheelchair in her room with a CPAP machine on top of a bedside drawer. The CPAP machine was connected to tubing with a nasal mask (a mask that fits in the nose) on top of Resident 6's bed. Resident 6 stated the facility staff did not check her CPAP machine. Resident 6 further stated she cleaned the mask herself.</p> <p>During an interview and concurrent observation on 4/4/24, at 10:16 A.M. with licensed nurse (LN) 1, LN 1 stated the CPAP masks for Resident 5 and Resident 6 should have been stored in a plastic bag to keep the equipment clean. LN further stated the oxygen tubing for Resident 5 should have been dated when it was last changed.</p> <p>During an interview on 4/4/24, at 10:25 A.M. with LN 2, LN 2 stated oxygen equipment should be stored in a plastic bag to prevent contamination and touching the floor.</p> <p>An interview was conducted on 4/4/24, at 11:51 A.M. with the assistant director of nursing (ADON). The ADON stated respiratory equipment should be stored in a plastic bag, covered, and dated for infection control.</p> <p>A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 3/2022 was reviewed. The P&P indicated, .Oxygen tubing is to be replaced every seven (7) days. Oxygen masks or nasal prongs are to be replaced every seven (7) days.</p> <p>(continued on next page)</p>		

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