

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 07/02/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518</p> <p>Based on observation, interview, and record review the facility failed to prevent an avoidable fall for one resident (Resident 2) who had a previous fall history.</p> <p>This failure caused the resident to sustain a right femoral neck fracture (a type of hip fracture).</p> <p>Review of Resident 2 ' s history and physical dated 10/12/23 indicated Resident 2 was admitted on [DATE] for diagnoses which include Pathological Fractures, Fracture of Odontoid Process (a bone in resident ' s spine), recurrent falls, and orthostatic hypotension(symptomatic low blood pressure when changing position). Per History and Physical, Resident 2 was .transferred from another SNF, where she was admitted after an unwitnessed fall and was unable to get up. Reportedly she had walked into dining room, felt lightheaded, then passed out .She also has history of another fall in 2/23 .Plan .Orthostatic vitals, careful position changed, Fall precautions .</p> <p>On 5/31/21 at 10 A.M. an interview with Certified Nursing Assistant (CNA) 3 was conducted. CNA 3 stated that he came to help CNA 2 after she called for help. CNA 3 stated Resident 2 was being attended to by CNA 2 and LN 1 when he arrived. CNA 3 stated that Resident 2 was sitting in the shower room on the bench. CNA 3 stated Resident 2 was lightheaded, so they took vital signs. CNA 3 stated her blood pressure was low but did not remember how low. CNA 3 helped get Resident back to bed with CNA 2 and LN 1. CNA 3 stated the expectation for fall risk resident was .Don ' t stand a resident up to clean them or clean them by yourself or have someone help you.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/31/24 at 11:00 A.M., an interview with CNA 2 was conducted. CNA 2 stated that she was not aware Resident 2 was a fall risk and did not know about any previous falls. CNA 2 stated that Resident 2 did not have a fall risk band or any indication that she was a fall risk. CNA 2 stated that she had showered the resident by herself in the past and had not had any other problems prior. CNA 2 stated that she had washed the resident ' s front and asked her to stand and hold the rail while doing perianal care on her. CNA 2 stated that as she turned to get the brief, Resident 2 fell to the floor, and seemed to pass out. CNA 2 stated she screamed for help. LN 1 and CNA 3 came to help, and they pulled Resident 2 up on the shower bench. CNA 2 stated they did vital signs on Resident 2 and her blood pressure was low. CNA 2 stated that when Resident 2 was stabilized, they got her back to wheelchair, and elevated her legs, and 911 was called to send Resident 2 to the hospital by ambulance. CNA 2 stated that if she knew Resident 2 was a fall risk, she would have given the resident a bed bath or used the shower chair, so resident would not have to stand up in the shower. CNA 2 stated that after Resident 2 fell they should have put a wrist band or a sign up to show that resident was a fall risk.</p> <p>On 5/31/24 at 11:25 A.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated that when Resident 2 fell , he was doing his medication pass, and he heard Help! from shower room. LN 1 stated Resident 2 was sitting on the shower bench, not responding to CNA 2 trying to wake her. LN 1 stated CNA 2 was not responding to voice or pain and was not alert. LN 1 stated that CNA 2 told him that Resident 2 fell over on her right side and hit her head on the floor, and she had pick her up and put her back on the bench. LN 1 stated he assessed Resident 2, did vital signs, and found no obvious head trauma or trauma to body. LN 1 stated they got resident covered and transported her back to the room, where they raised her feet up in bed, and resident regained consciousness. LN 1 stated that he was not aware of any fall history for Resident 2. LN 1 stated that Resident 2 spoke little English, but her son was there to translate, and Resident 2 was complaining of leg pain in Right leg, and son wanted LN 1 to call 911 to have Resident 2 go to the hospital. LN 1 called 911. LN 1 stated Resident 2 should have been flagged for fall risk on admission, if she had a history of falls, Resident should have had some way to determine if she was a fall risk, like a bracelet with fall risk, if Resident 2 was a known fall risk, should have been 2 person shower, and should not have let resident stand in the shower, but should have used shower chair.</p> <p>On 5/31/24 at 12:40 P.M., an interview was conducted with Resident 2 ' s Family Member (FM) 1. FM 1 stated that stated that initially Resident 2 had fallen last September and that was initially what brought her to hospital and then the SNF. FM 1 stated that this fall was the 2nd fall. FM 1 stated that since the fall the new protocol was to have Resident 2 taken to the shower in shower chair or shower gurney with 2 staff members. FM 1 stated that Resident 2 was on fall precautions in the past because of orthostatic hypotension. FM 1 stated that when Resident 2 fell , she only had one staff member in the shower with her. FM 1 stated that the shower process was .Haphazard, and he has to seek them out ., and he wanted to know what the policy was. FM1 stated that Resident 2 had a fall wrist bracelet at the hospital, but none was ever put on her at the SNF.</p> <p>On 5/31/24 at 12:55 P.M. an interview was conducted with LN 3. LN 3 stated that if a resident has a history of fall, they should have more than one staff in shower with the person and they should use a shower chair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/31/24 at 1:10 P.M., an interview with CNA 4 was conducted. CNA 4 stated that Fall risk residents in the shower: Use shower chair, always have 2 staff for transfers and in shower with fall risk resident when showering, do not stand residents up in the shower room because the floor is slippery in shower, and resident might fall. CNA 3 was unsure of how to know if a resident was a fall risk, only by looking in the electronic medical record.</p> <p>On 5/31/24 at 1:55 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated fall risk status of residents was by word of mouth through daily report, and they did not use wrist bands or signs to identify fall risk residents. The DON stated that the expectation would have been to use a shower gurney or shower chair with 2 staff members to give known fall risks residents a shower. The DON stated the importance of fall precautions is to prevent residents with history of falls from repeated falls.</p> <p>Review of LN 1 ' s Nursing Progress Notes dated 5/16/24 indicated .notified by CNA that resident fell . patient was presented in the bathroom bench. patient not responsive to verbal or pain stimuli. CNA stated patient was standing and holding onto bar. stated when turned to get brief patient fell . CNA state patient fell and hit her left side of head. CNA stated immediately pick up patient and placed on bench. upon inspection no obvious trauma to head. No signs of major bleeding. skin intact all over. assisted CNA x2 to bed. covered patient with new gown. v/s taken and follows BP 94/67, HR 62, RR 17, O2 97%. patient not on blood thinners. patient c/o of pain on right hip pelvic pain. patient became alert when in bed. patient dnr selective. son of patient at bedside. son approved to sent to er. md aware. adon aware. notified 911 emergent.</p> <p>Review of Fall Committee IDT Progress Notes dated 5/17/24 indicated .ROOT CAUSE: CNA stated Resident 2 was standing holding onto the safety bar while being showered. CNA stated that when she turned to get brief. Resident 2 fell and his right side of her head .Recommend pt to be rolled into show room on shower chair for future showers d/t low standing and activity tolerance OOB and orthostatic hypotension. Resident 2 to be 2 person assist with showers .</p> <p>Review of Discharge Summary from [NAME] Mercy Hospital dated 5/20/24 indicated that Resident 2 . presented after suffering a mechanical fall and later found to have displaced right femoral neck fracture. Patient underwent ORIF with right hemiarthroplasty of right hip on 5/17/24 .Hx of orthostasis .Patient history of recurrent falls .</p> <p>Review of MDS 3.0 Section C - Cognitive Patterns indicated Resident 2 had a BIMS Score of 11.</p> <p>Review of MDS 3.0 Nursing Home Part A PPS discharge date d 10/11/23, question J1700. Fall History on Admission/Entry or Reentry indicated Resident 2 had a fall in the last month prior to admission and that Resident 2 had a fracture related to the fall in 6 months prior to admission/entry or reentry.</p> <p>Review of undated policy and procedure entitled Nursing Clinical, Routine Procedures, Bath, Shower indicated for Dependent Residents indicated 1. Assist resident to shower room .9. Assist resident to room . 10. Cleanse and return shower chair to designated area .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy and procedure entitle Quality of Life/Fall Protocol dated 5/2007 indicated .Fall Risk Factors .Muscle/Joint Abnormalities .Orthostatic Hypotension Slipperiness of floors .Staff who are inappropriately trained to prevent falls secondary to: Incorrect safety assessment skills, Inappropriate transfer techniques .Newly admitted residents .Any resident with a history of falls .Pay particular attention to residents who are newly admitted ; those with a history of multiple falls and/or fractures, sustained at the facility; and those at risk for high injury from falls .</p>		