

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  10/08/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46235</p> <p>Based on observation, interview, and record review the facility failed to ensure three of four residents were provided care in a manner that promoted dignity and respect. (Resident 2, 3 and 4)</p> <p>These failures resulted in not ensuring resident's rights to be treated with respect and dignity with the potential to cause psychosocial harm to the involved residents.</p> <p>Cross reference F725</p> <p>Findings:</p> <p>1. Resident 2 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care and obstructive (hindrance of normal urine flow) and reflux uropathy (urine flowing backwards) according to the facility ' s Admission Record.</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/19/24, section C0500 indicated Resident 2 ' s score was 15, cognition (thinking, reasoning, or remembering) was intact. Section GG0130 indicated Resident 2 was dependent with toileting hygiene.</p> <p>During an observation and interview on 9/20/24 at 10:16 A.M., Resident 2 was lying in bed in her room. Resident 2 stated the facility ' s certified nurse assistants (CNA) were, Lazy. Resident 2 stated she always had to wait a long time to be changed.</p> <p>Resident 2 stated once her brief was changed at 9:30 A.M. and was not changed again until 7 P.M., which was over nine hours.</p> <p>Resident 2 stated she did not remember the date of the incident, but it made her very upset because she was dirty.</p> <p>Resident 2 ' s care plans were reviewed. A care plan for Resident 2 dated 7/14/24 indicated, .Has limited physical mobility r/t (related to) weakness .PT Clarification of orders to eval and tx (treat) . The care plan did not indicate providing assistance with</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 2 ' s toileting needs and other activities of daily living (ADL- basic tasks of everyday life).</p> <p>2. Resident 3 was admitted to the facility on [DATE] with diagnoses including abnormalities of gait (walking) and mobility and aftercare following joint replacement surgery according to the facility ' s Admission Record.</p> <p>During a review of nurse practitioner ' s (NP) progress note (PN) dated 8/26/24 for Resident 3, the PN indicated, .Oriented to person, place, time, and surroundings. Remote and long-term memory appears intact .</p> <p>During an observation and interview of Resident 3 on 9/20/24 at 10:32 A.M., Resident 3 was observed exiting room eight holding a breakfast tray and stood in the hallway looking for staff. The light outside room eight was on. Resident 3 stated she and her roommate pressed their call light 30 minutes ago and nobody came. A staff member was passing by room eight and took the tray from Resident 3. Resident 3 then entered room eight and stated there had been times when she and her roommate waited two hours for staff to come and assist them. Resident 3 stated she felt bad that her roommate had to wait a long time to be changed. Resident 3 stated her first week at the facility (8/25/24 through 8/27/24), she pressed the call light button because she needed to go to the bathroom. Resident 3 stated she just had left knee surgery and was not able to walk on her own. Resident 3 stated she waited one hour and had to hold her urine before anyone came to help her. Resident 3 stated she was so upset she wanted to leave the facility, but the social worker convinced her to stay.</p> <p>During a review of Resident 3 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/31/24, section GG0130 indicated Resident 3 required partial/ moderate assistance with toileting hygiene. Section GG0170 indicated Resident 3 required supervision or touching assistance with toilet transfer.</p> <p>Resident 3 ' s care plans were reviewed. A care plan for Resident 2 initiated on 8/26/24 indicated, .has an ADL Self Care Performance Deficit r/t Limited Mobility, Activity Intolerance, Impaired balance, Pain . Occupational, Physical, Speech-Language Therapy evaluation . The care plan did not address assisting Resident 3 with toileting and other ADLs.</p> <p>3. Resident 4 was admitted to the facility on [DATE] with diagnoses including myelodysplastic syndrome (a type of cancer) and need for assistance with personal care according to the facility ' s Admission Record.</p> <p>During a review of the physician ' s history and physical (H&amp;P) dated 7/30/24 for Resident 4, the H&amp;P indicated, .Mental Status: The patient was alert, oriented x 3 (person, time and place) .patient has capacity to make their own complex medical decisions .</p> <p>An observation and interview of Resident 4 was conducted on 9/20/24 at 10:32 A.M. Call light outside Resident 4 ' s room was on. Resident 4 was observed in her room sitting on a cloth pad at the edge of the bed. Resident 4 stated her brief had been wet since last night and nobody today, 9/20/24 day shift had come to change her. Resident 4 stated call light response has been a problem.</p> <p>Resident 4 stated she had to urinate multiple times on the brief and the urine seeps through the pads on the bed which made her very uncomfortable.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/14/24, section GG0130 indicated Resident 4 required dependent assist with toileting hygiene. Section GG0170 of the MDS indicated Resident 4 required partial/moderate assistance with toilet transfer.</p> <p>A review of Resident 4 ' s care plans were conducted. The ADL care plan initiated on 8/5/24 indicated, .Self Care Performance Deficit r/t Limited Mobility .RNA [Restorative Nurse Assistant] for BUE (bilateral upper extremity) ROM (range of motion) and BLE (bilateral lower extremity) ROM . The care plan did not indicate assisting Resident 3 with toileting and other ADLs.</p> <p>An interview was conducted with licensed nurse (LN) 1 on 9/20/24 at 10:57 A.M. LN 1 stated her expectation for answering residents ' call lights should be within five to ten minutes. LN 1 stated one hour wait time was too long because the resident could be in distress. LN 1 further stated if the resident was wet, the resident ' s skin would be compromised and develop a moisture associated dermatitis (MASD- inflammation of the skin from extended exposure to bodily fluids).</p> <p>During an interview with LN 2 on 9/20/24 AT 11:23 A.M., LN 2 stated she expected call lights to be answered in a timely manner within five to ten minutes. LN 2 stated if a resident was wet, the resident can develop a pressure injury (bedsore) or infection.</p> <p>An interview was conducted ON 9/20/24 at 11:23 A.M. with certified nurse assistant (CNA) 1. CNA 1 stated residents ' call lights should be answered under three minutes. CNA 1 stated a resident could develop pressure sores if the resident waited an hour and would not feel comfortable.</p> <p>The director of staff development (DSD- a licensed nurse certified for staff training) was interviewed on 9/20/24 at 11:33 A.M. The DSD stated it was everyone ' s responsibility to answer call lights within five minutes. The DSD stated she taught CNAs to communicate with the resident if the CNA was not able to assist the resident at the time and find someone who can assist the resident. The DSD further stated if a resident was wet with urine and waited an hour, the resident would develop skin breakdown and infection.</p> <p>During an interview on 10/8/24 at 1:43 P.M. with the Assistant Director of Nurses (ADON), the ADON stated a resident having to wait to be changed while wet was a dignity issue because it was embarrassing. The ADON stated having to ask to be changed was already a dignity issue because it took away residents ' independence and residents were vulnerable.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled, Resident Rights .Dignity and Respect, dated 12/2/2 was conducted.</p> <p>The P&amp;P indicated, .It is the policy of this facility that all residents be treated with kindness, dignity and respect .Resident will be appropriately dressed in clean clothes arranged comfortably .</p> <p>During a review of the facility ' s P&amp;P titled, Continence Maintenance Program, revised 3/2024, the P&amp;P indicated, .Check the resident at regular intervals .Provide perineal care and change absorbent product if wet .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46235</p> <p>Based on observation, interview, and record review the facility failed to ensure sufficient staffing was provided for the residents of the facility when:</p> <ol style="list-style-type: none"> <li>1. Resident 2 ' s brief was not changed for over nine hours.</li> <li>2. Resident 3 held her urine for an hour before staff came to assist.</li> <li>3. Resident 4 ' s brief was not changed for over four hours.</li> </ol> <p>As a result, Residents 2 and 3 sat on a soiled and wet pad, and Resident 4 waited over 4 hours to be changed. Failure to change a soiled, wet pads had the potential for residents to develop a skin breakdown and the potential to affect their emotional and psychosocial well-being.</p> <p>Cross reference F550</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Resident 2 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care and obstructive (hindrance of normal urine flow) and reflux uropathy (urine flowing backwards) according to the facility ' s Admission Record.</li> </ol> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/19/24, section C0500 indicated Resident 2 ' s score was 15, cognition (thinking, reasoning, or remembering) was intact. Section GG0130 indicated Resident 2 was dependent with toileting hygiene.</p> <p>During an observation and interview on 9/20/24 at 10:16 A.M., Resident 2 was in bed in her room. Resident 2 stated the facility ' s certified nurse assistants (CNA) were, Lazy. Resident 2 stated she always had to wait a long time to be changed. Resident 2 stated once her brief was changed at 9:30 A.M. and was not changed again until 7 P.M., which was over nine hours. Resident 2 stated she did not remember the date of the incident.</p> <p>Resident 2 ' s care plans were reviewed. A care plan for Resident 2 dated 7/14/24 indicated, .Has limited physical mobility r/t (related to) weakness .PT Clarification of orders to eval and tx (treat) . The care plan did not indicate providing assistance with Resident 2 ' s toileting needs and other activities of daily living (ADL- basic tasks of everyday life).</p> <ol style="list-style-type: none"> <li>2. Resident 3 was admitted to the facility on [DATE] with diagnoses including abnormalities of gait (walking) and mobility and aftercare following joint replacement surgery according to the facility ' s Admission Record.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0725</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&amp;P) titled, Call Light/Bell, was conducted. The P&amp;P indicated, .Answer the light/bell within a reasonable time (at least less than 5 minutes) .</p> <p>The facility did not provide a policy and procedure for staffing the facility.</p>		