

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	

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 - 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** 37409</p> <p>Based on interview and record review, the facility failed to ensure supervision was provided to one of three residents (Resident 1) who was assessed to be high risk for falls, totally dependent on staff for transferring, and required close monitoring (staff made rounds and observed the residents at risk of falling) when Resident 1 was left sitting in her wheelchair in the hallway without staff watching and/or supervising her on [DATE], at 6:45 a.m., when staff went inside another resident's room. This failure resulted in Resident 1 falling on the floor and sustaining a subdural hematoma (occurs when a blood vessel in the space between the skull and the brain is damaged; blood escapes from the blood vessel, leading to the formation of a blood clot that places pressure on the brain and damages it) on the right temporal region (a region at the side of the head behind the eyes). This blunt force injury of her head was the immediate cause of her death after 15 days in the general acute care hospital (GACH).</p> <p>Findings:</p> <p>Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), epilepsy (characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body and are sometimes accompanied by loss of consciousness and control of bowel or bladder function), muscle weakness, abnormality of gait and mobility, and a history of falling.</p> <p>Review of Resident 1's Nursing Fall Risk Evaluation , dated [DATE], [DATE], and [DATE], indicated that Resident 1 was at high risk for falls.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a clinical assessment tool), dated [DATE], indicated that Resident 1's cognition was moderately impaired, and she needed extensive assistance (staff provide weight-bearing support) with one-person physical assist in transferring to moving between surfaces including to or from bed, a chair, her wheelchair, and in and out of a standing position.</p> <p>Review of Resident 1's Change of Condition , dated [DATE], at 3:50 p.m., indicated on [DATE] at around 3:50 p.m., Resident 1 was witnessed standing up from her wheelchair and holding on to the hallway rail. Resident 1 slightly lost her balance. A staff went to Resident 1 and assisted her slowly to the floor.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Interdisciplinary Team (IDT, a group of healthcare professionals who work together to provide the residents with the care they need) Notes, dated [DATE] at 3:41 p.m., indicated that the IDT recommended that Resident 1 should be on closely monitored by group resident monitor staff (a staff assigned to make rounds and observe the residents who are at risk for falling).</p> <p>Review of Resident 1's Change of Condition , dated [DATE], at 1:06 a.m., indicated on [DATE] at 1:06 a.m., Resident 1 was found on her room floor and wrapped in her blanket. Resident 1 sustained a 4 centimeter (cm, a metric unit of length) by 4 cm bump on the right side of her forehead.</p> <p>Review of Resident 1's activities of daily living (ADLs, a person's daily self-care activities) care plan, dated [DATE], indicated that Resident 1 was totally dependent on one staff for transferring.</p> <p>Review of Resident 1's at risk for fall care plan, dated [DATE], indicated that the interventions included were that the facility would closely monitor Resident 1 by group resident monitor staff and frequently check Resident 1 for safety and needs to attain a goal that Resident 1 would not sustain a serious injury related to a fall.</p> <p>Review of Resident 1's Change of Condition , dated [DATE], at 6:45 a.m., indicated on [DATE] at 6:45 a.m., Resident 1 was up on her wheelchair in the hallway and that certified nursing assistant A (CNA A) went inside a room to collect the garbage. When CNA A walked out of the room, he noted Resident 1 was on the floor on her right side. Resident 1 apparently had fallen and had sustained a 3 cm by 3 cm bump on her right frontal area. This fall incident resulted in Resident 1 being transferred to the GACH on [DATE] for further evaluation and management.</p> <p>During an interview with CNA A on [DATE], at 2:20 a.m., he stated he could not recall the date but could recall the incident that happened (referring to the incident that happened on [DATE])as it was about the end of the night shift when Resident 1 was up in the wheelchair in the hallway. CNA A stated he was in Resident 1's room helping Resident 1's roommate. When he walked out of the room, he saw Resident 1 on the floor.</p> <p>During an interview with license vocational nurse B (LVN B) on [DATE], at 10:45 a.m., she stated she could not recall the date but could recall the incident that happened (referring to the incident that happened on [DATE]) as it was about the end of the night shift. Resident 1 was up in the wheelchair in the hallway. There were no staff there with Resident 1 at that time because everybody was busy because it was the end of the shift. Then a CNA notified her that Resident 1 had fallen. She came over and saw that Resident 1 was on the floor, and upon assessment Resident 1 had sustained a bump on her forehead. She called the physician and received an order to send Resident 1 to the GACH emergency room via 911 for further evaluation and treatment.</p> <p>Review of Resident 1's Emergency Provider Report, dated [DATE], indicated Resident 1 was brought in by ambulance for a fall off her wheelchair at the facility that morning, and that Resident 1 had a right forehead hematoma (a localized swelling that is filled with blood caused by a break in the wall of a blood vessel). Resident 1 was admitted to the GACH for further monitoring and management and remained admitted in the hospital from [DATE], until the date of her death on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's head computed tomography scan (CT scan, an imaging test that uses a series of X-rays and a computer to create detailed images of the bones and soft tissues) Diagnostic Imaging Report, dated [DATE], indicated Resident 1 had sustained a 3.5 millimeter (mm, a metric unit of length) subdural hematoma right high temporal region.</p> <p>Review of Resident 1's Discharge Summary from the GACH, dated [DATE], indicated Resident 1 was pronounced dead at around 9:35 p.m. on [DATE].</p> <p>Review of Resident 1's Certificate of Death, dated [DATE], indicated that blunt force injury of her head from her fall on [DATE] was the immediate cause of her death.</p> <p>During an interview with the director of nursing (DON) on [DATE], at 2:35 p.m., she stated she was on vacation at the time Resident 1 fell on [DATE]. The DON further stated that Resident 1 was supposed to have someone watching her.</p> <p>During an interview with the MDS Assistant (MDSA) on [DATE], at 4:35 p.m., she reviewed Resident 1's clinical record and stated since Resident 1 needed extensive assistance with one-person physical assist in transferring, staff should have watched Resident 1 while she was in the wheelchair because Resident 1 would have fallen if she stood up by herself.</p> <p>During an interview with the DON on [DATE], at 11:20 a.m., the DON stated Resident 1 was placed in a wing in the facility with other residents who were at risk for fall. The DON also stated that in morning shift and evening shift, a group resident monitor staff would make rounds in the wing and observe the residents, but during night shift, there was no group resident monitor staff assigned but the CNA were supposed to observe the residents in the wing.</p> <p>However, during the time Resident 1 fell on [DATE], at 6:45 a.m., Resident 1 was left sitting in her wheelchair in the hallway by herself, completely unmonitored and unsupervised.</p> <p>Review of the facility's policy, Fall Management Program, dated ,d+[DATE], indicated The facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls . Avoidable accident is an accident which occurred because the facility failed to: . Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan, and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident.</p>		