STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055114	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Nursing Center	7800 Parkway Drive LA Mesa, CA 91942

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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to complete an Admission Comprehensive Assessment according to the Minimum Data Set (MDS-A clinical assessment tool), a Federal requirement by Centers for Medicare and Medicaid Services (CMS) for one of 16 resident's (Resident 109) reviewed during a re-visit for Resident Assessments. This failure had the potential for Resident 109 not to be completely assessed for potential health issues and for CMS to be unaware of the resident current health status or location. Findings: According to the facility's Admission Record, dated 11/14/24, Resident 109 was admitted to the facility with diagnoses that included falls and fractures left femur (left thigh). On 12/12/24 Resident 109's clinical record was reviewed: The Admission MDS, dated [DATE], indicated the comprehensive assessment was, in progress. An interview and record review was conducted with the Assistant Director of Nursing (ADON) on 12/12/24 at 3:44 P.M., of Resident 109's MDS Admission comprehensive assessment. The ADON stated their Minimum Data Set Nurse (MDSN) quit on 11/20/24, and they have just hired a replacement. The ADON stated The Admission Comprehensive assessments were mandated to be complete 14 days after admission. The ADON reviewed Resident 109's MDS, dated [DATE], listed as , in progress, and stated the comprehensive assessment was never completed and it should have been on 11/28/24, because it was now overdue. The ADON stated by not completing the Admission comprehensive assessment, CMS was not informed and there was not a clear picture of the resident's admission health status. An interview was conducted with the Director of Nursing (DON) on 12/12/24 at 3:47 P.M. The DON stated the Admission MDS should have been completed, and she was unaware if was not. An interview was conducted with the Administrator (ADM) on 12/12/24 at 3:54 P.M. The ADM stated when the former MDSN left, he assumed all the MDS assessments were completed. The ADM stated Resident 109's MDS should have been completely in a timely manner and it was not. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	According to the Resident Assessment Instrument (a federal tool used to develop the MDS to assess the residents' needs, strengths, and preferences), dated October 2019, .Coding Instructions for A0310E, is the first of these assessments since the most recent admission/reentry, .within 14 days of Admission .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interviews, and record review, the facility did not develop and implement resident specific care plans related to PTSD (PTSD-an anxiety disorder that comes from a traumatic event) and limited range of motion (ROM) for 2 of 18 residents reviewed for care planning. (Resident 27 and Resident 294) Cross reference F688 and F699 As a result, Resident 27 did not receive care to address the decline in ROM in Resident 27's hands. In addition, Resident 294 had the potential to be retraumatized. Findings: 1.Resident 27 was admitted to the facility on [DATE] with diagnoses including osteoporosis (condition in which bones become weak and brittle) according to the facility's Admission Record. During an initial tour of the facility on 10/29/24 at 9:40 A.M., an observation and interview of Resident 27 was conducted. Resident 27 was observed lying in bed in his room with a blanket. Resident 27 stated the facility staff Did not help me cut up my pancakes. Resident 27 stated he needed assistance cutting up food. During the interview, Resident 27's hands were observed. The resident's fingers on both hands were bent at a 90-degree angle and when asked to demonstrate, the resident was unable to fully extend and straighten his fingers. An interview was conducted on 10/30/24 at 4:32 P.M. with certified nurse assistant (CNA) 1. CNA 1 stated he worked at the facility for ten years and knew Resident 27 very well. CNA 1 stated Resident 27 was able to feed himself, however Resident 27 could not fully open both hands and at times required feeding assistance. CNA 1 stated Resident 27's fingers were not bent. CNA 1 further stated that Resident 27 had bent fingers and had not been able to open his hands fully for approximately three years. During a review of Resident 27's care plans, there was no care plan regarding Resident 27's limited ROM. During an interview and joint record review on 10/31/24 at 3:25 P.M. with licensed nurse (LN) 3, LN 3 was asked if she had seen Resident 27's hands. LN 3 replied, No. A joint observation on 10/31/24 at 3:25 P.M. of Resident 27 was conducted in Resident 27's room. Resident 27 showed LN 3 his hands. Resident 27 was not able to fully open both hands and had difficulty spreading his fingers. LN 3 stated Resident 27's hands were contracted (a permanent tightening of joints preventing normal movement). LN 3 stated Resident 27 should have a hand brace or a washcloth to maintain Resident 27's mobility. LN 3 reviewed Resident 27's care plans and stated there was no care plan regarding Resident 27's hands or resident's risk for a decline in range of motion. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/31/24 at 4:04 P.M. with CNA 6. CNA 6 stated Resident 27 required assistance using a spoon during meals. CNA 6 stated Resident 27 needed assistance because it was difficult for Resident 27 to hold a spoon and would eat very slow. CNA 6 stated Resident 27 did not have problems holding a spoon before but Resident 27's hands had worsened. CNA 6 stated he was unsure when Resident 27 started having difficulty holding a spoon. During an interview on 11/1/24 at 3:55 P.M. with the DON, the DON stated it was her expectation for a CNA to report a resident's change in condition to the licensed nurse. The DON stated the IDT will assess and formulate a plan of care. The DON stated it was important to identify a change in resident's condition timely to formulate a care plan with an intervention to address the change in condition. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022 was conducted. The P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change . 49330 2. A review of Resident 294's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included PTSD (PTSD, a disorder in which a person has difficulty recovering after experiencing a terrifying event), depression, and alcohol use. A review of Resident 294's written care plan for PTSD dated 10/29/24 did not include Resident 294's triggers (situation that causes a person to remember a traumatizing event) for PTSD. On 10/30/24 at 11:28 A.M., a joint interview and record review was conducted with the Social Services Director (SSD). The SSD stated Resident 294 did not have interventions specific to PTSD and addressed his triggers. The SSD stated it was important to know Resident 294's triggers .because we want to prevent the resident from experiencing triggers. We want them to feel comfortable here, to feel safe . On 11/1/24 at 3:34 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, . it's important to avoid distress for the resident .if the resident has a trigger then they could experience psychological distress .a care plan is important so [nurses and CNA's] know how to take care of the patient. It's important to give trauma-informed care . A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, .Services provided for or arranged by the facility and outlined in the comprehensive care plan are . trauma-informed . A review of the facility policy titled, Trauma-Informed and Culturally Competent Care Level 3, revised August 2023, indicated, .Develop individualized care plans that address past trauma in collaboration with the resident .Identify and decrease exposure to triggers that may re-traumatize the resident .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to ensure a comprehensive care plan was revised and updated for one of five residents (Resident 15) reviewed for nutrition. As a result, the resident had the potential for further weight loss and health decline. Findings: According to the Admission Record, Resident 15 was admitted on [DATE] with diagnoses that included protein-calorie malnutrition (not enough protein or calories eaten to meet nutritional needs). A review of Resident 15's Interdisciplinary (IDT) Note indicated Resident 15 had a significant, unplanned weight loss of 18.3 pounds in one month. On 10/31/24 at 2:59 P.M. an interview was conducted with the Registered Dietitian (RD). The RD stated Resident 15's weight loss .was not an intentional weight loss .She had sudden significant weight loss .its not desirable, it means you are not meeting [Resident 15's] nutritional needs. The RD acknowledged that Resident 15's nutritional care plan was not updated to reflect the recent weight loss. A review of Resident 15's Care Plan indicated there were no revisions or interventions related to the weight loss. On 11/1/24 at 3:34 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that a plan of care was updated for Resident 15. The DON stated .she's already at risk for weight loss. We don't want her to deteriorate. A review of the facility's policy and procedure titled Weight Assessment and Intervention revised March 2022 indicated, Care planning for weight loss .is a multidisciplinary effort .care plans shall address .the identified causes of weight loss; goals and benchmarks for improvement; and .time frames and parameters for monitoring and reassessment . A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised March 2022 indicated, .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record reviews, the facility failed to provide interventions (care) according to the comprehensive care plan to prevent foot injury for one of 12 residents (Resident 42) reviewed with diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). As a result, Resident 42 was hospitalized with a left foot swelling (buildup of fluid in the tissues caused by the body's defense response to injury or infection) due to abrasions with the potential for diabetic foot complications. Findings: A review of Resident 42's Admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included a history of diabetes and gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) on the left second toe. A record review of Resident 42's MDS (Minimum data set: nursing facility assessment tool) dated 8/31/24 indicated that Resident 42 was rarely or unable to understand others or make self-understood and had severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to make decisions. A record review of Resident 42's Medical Doctor (MD) progress note dated 12/8/23, indicated, .Discussed with [MD NAME] the management of 2nd left toe dry gangrene .high risk of poor healing and further gangrene . According to the web article titled YOUR FEET AND DIABETES, published by Centers for Disease Control (CDC), dated May 15, 2024, .Diabetes can reduce blood flow and damage nerves, making a wound more likely to get infected and harder to heal, and increasing the risk of amputation .Tips for healthy feet .Wear shoes that fit well . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 9:11 A.M., a joint interview, and record review was conducted with LN 31. LN 31 stated Resident 42 had a history of gangrene to his second left toe which was auto-amputated (fell off by itself) and resolved on 9/6/24. LN 31 stated that the new abrasions on Resident 42's left great toe and left third toe were discovered on 10/26/24. LN 31 stated that she initiated a change of condition (COC) note dated 10/26/24, indicated, .up in wheelchair and wheels himself .Resident noted with abrasion on Left great toe and left 3rd toe .Resident also noted with +2 edema [swelling] on left foot .LN 31 stated on 10/26/24 she had spoken to Resident 42's family member because they were concerned why Resident 42's shoes were not on when he was in his wheelchair and had new wounds on Resident 42's left great toe and left third toe. LN 31 stated that Resident 42 was on his wheelchair and that Resident 42 would wheel himself to move around but was not wearing shoes that day. LN 31 stated there was a care plan with an intervention that indicated, dm shoes on bilateral lower extremities but was not included in the new care plan she had initiated on 10/26/24 for the left great toe and left third toe. LN 31 stated Resident 42 owned shoes and should have been wearing his shoes when he was on the wheelchair. LN 31 stated it was important for Resident 42 to wear well-fitted shoes for protection because of his prior history of gangrene on his second left toe as complicated by poor circulation of DM. A record review of Resident 42's MD orders dated 10/26/24 indicated, .Cleanse abrasion on left 3rd toe with normal saline. Pat dry, Apply bacitracin then cover with dry dressing Daily for 21 days .Cleanse abrasion on left great toe with normal saline. Apply bacitracin then cover with dry dressing Daily for 21 days . A record review of Resident 42's progress note on 10/28/24 at 10:05 P.M. indicated, Resident was transferred to [Acute Hospital Name] .due to concern of resident's swollen left foot . A record review of Resident 42's clinical record indicated a care plan undated indicated, Scratch on top of left hand r/t scratching .Will develop clean and intact skin by the review date .DM shoes on bilateral extremities . A requested care plan with initiated and revised dates from medical records (MR) was received on 10/30/24 indicated care plan was initiated on 10/22/24 and revised 10/24/24 with intervention .DM shoes on bilateral extremities . was omitted (removed). A record review of Resident 42's clinical record was conducted. There was no documentation for DM shoes on bilateral lower extremities was monitored or applied. On 10/31/24 at 2:31 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the plan of care was for Resident 42 to be wearing shoes, then it should have been performed to provide foot care protection and prevent complications. A review of the facility's policy and procedure titled FOOT CARE dated November 2017, indicated . Provide foot care and treatment, in accordance with professional standards of practice, including, preventing complications from the resident's medical condition(s) .

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F 0688

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46235

Based on observation, interviews, and record review the facility failed to identify and address a decline in range of motion (ROM - how far a joint can move or stretch) for one of two residents (Resident 27) reviewed for limited range of motion.

This failure resulted in a decline Resident 27's full movement potential of his hands (such as fully closing his hands to grasp or make a fist), which made it difficult for Resident 27 to cut up food items and fully grasp utensils during meals. In addition, this failure had the potential for Resident 27 to independently complete all other activities of daily living such as grooming, dressing and personal hygiene.

Findings:

A review of Resident 27's undated Admission Record indicated that Resident 27 was admitted to the facility on [DATE] with diagnoses including osteoporosis (condition in which bones become weak and brittle).

During an initial tour of the facility on 10/29/24 at 9:40 A.M., an observation and interview of Resident 27 was conducted. Resident 27 was observed lying in bed in his room with a blanket. Resident 27 stated the facility staff Did not help me cut up my pancakes. Resident 27 stated he needed assistance cutting up food. During the interview, Resident 27's hands were observed. The resident's fingers on both hands were bent at a 90-degree angle and when asked to demonstrate, the resident was unable to fully extend and straighten his fingers.

An interview was conducted on 10/30/24 at 4:32 P.M. with certified nurse assistant (CNA) 1. CNA 1 stated he worked at the facility for ten years and knew Resident 27 very well. CNA 1 stated Resident 27 was able to feed himself, however Resident 27 could not fully open both hands and at times required feeding assistance. CNA 1 stated Resident 27's fingers were bent. CNA 1 further stated that Resident 27 had bent fingers and had not been able to open his hands fully for approximately three years.

During an interview on 10/31/24 at 8:54 A.M. with CNA 3, CNA 3 stated a change in a resident's condition should be reported to a licensed nurse. CNA 3 stated skin changes, refusal of care, a resident who was not eating and a change in ROM should be reported to a nurse.

During an interview on 10/31/24 at 9:07 A.M. with CNA 4, CNA 4 stated a change in resident's condition should be reported to a nurse. CNA 4 stated a resident who was not eating, refusing shower, refusing therapy, a resident who was weak or unable move arms or legs were considered a change in condition.

(continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview and joint record review on 10/31/24 at 3:25 P.M. with licensed nurse (LN) 3, LN 3 was asked if she had seen Resident 27's hands. LN 3 replied, No. A joint observation on 10/31/24 at 3:25 P.M. of Resident 27 was conducted in Resident 27's room. Resident 27 showed LN 3 his hands. Resident 27 was not able to fully open both hands and had difficulty spreading his fingers. LN 3 stated Resident 27's hands were contracted (a permanent tightening of joints preventing normal movement). LN 3 stated Resident 27 should have a hand brace or a washcloth to maintain Resident 27's mobility. LN 3 reviewed Resident 27's care plans and stated there was no care plan regarding Resident 27's hands or resident's risk for a decline in range of motion. LN 3 further reviewed physician orders for Resident 27 and stated there was no order for rehab or restorative nursing assistant (RNA- a CNA who work alongside rehab staff to provide exercises for residents with limited mobility). An interview was conducted on 10/31/24 at 4:04 P.M. with CNA 6. CNA 6 stated Resident 27 required assistance using a spoon during meals. CNA 6 stated Resident 27 needed assistance because it was difficult for Resident 27 to hold a spoon and would eat very slow. CNA 6 stated Resident 27 did not have problems holding a spoon before but Resident 27's hands had worsened. CNA 6 stated he was unsure when Resident 27 started having difficulty holding a spoon. An interview was conducted on 11/1/24 at 8:04 A.M. with LN 5. The LN 5 stated nursing staff referred the residents to their attending physicians when a resident had trouble walking, difficulty with exercises or experienced ROM stiffness. LN 5 stated physical therapists will then assess the resident if appropriate for therapy or RNA. LN 5 further stated she was unsure of Resident 27's problems with his hands but Resident 27 was referred to rehab on 11/1/24 due to hand stiffness. An interview was conducted on 11/1/24 at 8:09 A.M. with the physical therapist (PT- focuses on improving a resident's ability to move their body) assistant (PTA). The PTA stated residents were referred to rehab on admission and from nursing report of resident change in condition. The PTA further stated all residents were screened by physical therapy on a quarterly basis for any change in condition. During an interview on 11/1/24 at 8:13 A.M. with the Director of Rehabilitation (DOR), the DOR stated a calendar was provided by the Minimum Data Set Nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents) for quarterly screening of residents. The DOR stated he will ask the MDSN for Resident 27's last quarterly rehab screen. The DOR stated Resident 27 was scheduled for physical therapy (PT) and occupational therapy (OT) evaluation on 11/1/24 for Potential wrist contracture referred by the nursing staff. A joint observation of Resident 27's hands was conducted with the Director of Nurses (DON) on 11/1/24 at 8:50 A.M. The DON held Resident 27's hands and Resident 27's fingers were bent at a 90-degree angle and Resident 27 was not able to fully close both hands. Resident 27 stated his hands have been in that condition for a few months. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A joint observation and interview of Resident 27 was conducted with occupational therapist (OT- a healthcare provider who helps people learn or regain skills of daily living) 1 and OT 2 on 11/1/24 at 8:55 A.M. The DON was present during the observation and interview. OT 1 attempted to straighten Resident 27's left fingers up and Resident 27 stated, Ow. OT 1 attempted to straighten Resident 27's right fingers up and Resident 27 was not able to straighten his fingers to fully open his hand. OT 2 asked Resident 27 if he had arthritis and Resident stated, No. OT 2 asked Resident 27 how long his hands had been in the condition it was in and Resident 27 stated, A long time. OT 2 attempted to straighten Resident 27's fingers from a bent position and was unsuccessful. Resident 27 was also not able to spread his fingers or move the thumb up. OT 2 stated Resident 27's hand limitations were not recent, and Resident 27 must have had the limitations for a long period of time. During an interview on 11/1/24 at 9:56 A.M. with the DOR, the DOR stated he was not able to find quarterly rehab screens for Resident 27. A call was made on 11/1/24 at 10:19 A.M. to Resident 27's attending physician to discuss Resident 27's health status. The answering service for the attending physician stated a Nurse Practitioner was covering for the physician and should return the call. During an interview on 11/1/24 at 11:10 A.M. with the DON, the DON stated Resident 27's hand limitations were identified on 10/31/24 by the MDSN. During a joint record review and interview with the MDSN on 11/1/24 at 11:50 A.M., the MDSN stated an Interdisciplinary (IDT- team members with various areas of expertise who work together toward the goals of their residents) GG (the functional abilities and goals section of the MDS) meeting was conducted quarterly to discuss all residents' status. The MDSN stated on 7/24/24 a form titled, IDT: Functional Abilities and Goals was completed and indicated no impairment of Resident 27's range of motion. The MDSN stated there was no other documentation to show Resident 27's ROM status. The MDSN stated she was not aware of Resident 27's hand limitations because she had not assessed the resident. A telephone call was made by this writer on 11/1/24 at 12:57 P.M. to Resident 27's daughter who was an emergency contact according to Resident 27's Admission Record. A message was left to return call to discuss Resident 27's health status. During joint record review and interview with OT 2 on 11/1/24 at 3:11 P.M., OT 2 stated she completed an evaluation of Resident 27's hands. OT 2 stated Resident 27's joints in his hands were fixed in flexed position and they were considered impaired. Passive ROM during evaluation caused resident to have pain and the resident was not able to perform active ROM of both hands. OT 2 stated Resident 27's carpal metacarpal joints (CMC-base of thumb where it meets the hand) on both hands were flexed at 90 degrees and could not extend. OT 2 stated Resident 27's proximal interphalangeal (PIP-joints in the finger connecting the first two bones) joints on both hands and the distal interphalangeal (DIP-hinge joints at tip of fingers) joints on both hands were in extension. OT 2 stated Resident 27 was not able to flex (bend) the joints. OT 2 further stated occupational therapy treatment for Resident 27 will be for prevention to prevent further flexion only. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of the occupational therapy evaluation for Resident 27 titled, OT Evaluation & Plan of Treatment, dated 11/1/24, was conducted. The evaluation indicated, .Eating .Long-Term Goals .Pt will tolerate wearing resting hand splint three hours per day .to improve digit [fingers] extension for functional engagement in ADL [activity of daily living] tasks .Musculoskeletal System Assessment .Contracture .Functional Limitations Present due to Contracture= Yes; Functional Limitations as Result of Contracture(s): limited functional ability to perform ADLs; pt baseline receive [sic] assistance for ADL tasks from CAN staff . A review of Resident 27's MDS assessments dated 1/26/24, 4/25/24 and 7/24/24 was conducted. MDS Section GG0115 for all three MDS assessments titled, Functional Limitation in Range of Motion indicated .0 [no impairment] .Upper extremity [shoulder, elbow, wrist, hand] . During an interview on 11/1/24 at 3:55 P.M. with the DON, the DON stated it was her expectation for a CNA to report a resident's change in condition to the licensed nurse. The DON stated the IDT will assess and formulate a plan of care. The DON stated it was important to identify a change in resident's condition timely to formulate a care plan with an intervention to address the change in condition. During an interview on 11/1/24 at 4:20 P.M. at the Quality Assessment and Improvement Plan (QAPI-a plan to improve the overall quality of life and quality of care and services delivered to nursing home residents) meeting with the DON, the DON stated she was not aware of the four disciplines (CNA, licensed nurse, MDS nurse and rehab staff) who missed assessing Resident 27's decline in ROM. The DON acknowledged Resident 27's decline in range in range of motion was not identified until 10/31/24. A review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated July 2017 was conducted. The P&P indicated, .Residents will not experience an avoidable reduction in range of motion [ROM] .Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER: Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7800 Parkway Drive LA Mesa, CA 91942	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956 Based on interview and record review the facility failed to ensure one of three resident's (Resident 86) pain medication order was clarified to include parameters (how much medication to give based on the residents stated pain level on a 0-10 scale) and frequency of administration. This failure had the potential for Resident 86 to have uncontrolled pain or to be over medicated. Findings: According to the Admission record, Resident 86 was admitted to the facility on [DATE] with diagnoses including post laminectomy (back surgery). During a record review of Resident 86's Medication Administration Record (MAR), Resident 86 had an order for Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth as needed for Twice daily as needed for pain management. 2x daily as needed for pain. Start date 10/24/2024 0900. During an interview on 11/1/2024 at 9:50 A.M., with the Infection Preventionist (IP), IP stated a pain medication order needed to have the medication name, dose, route, frequency, length, reason, and pain parameters. The IP stated it was her expectation that the order would have been clarified because it was missing the frequency and the parameters for giving the medication. The IP stated the nurse should have called the physician for clarification. The IP stated without any clarification, the licensed nurse could overdose the resident. During an interview on 11/1/2024 at 10:20 A.M., with Licensed Nurse 2 (LN 2), LN 2 stated that a PRN (as needed) medication order needed to be very specific. LN 2 stated it needed to have a time frequency for how often it could be given. LN 2 stated this order should have been clarified as soon as it was received and no one should have given the medication without clarification. LN 2 further stated Resident 86 could get too much medication. During an interview on 11/1/2024 at 2:35 P.M., with the Director of Nursing (DON), the DON stated PRN pain medication orders needed the name of the medication, the dose, the route, frequency and reason. The DON stated this order was missing the parameters for time and for pain levels. The DON stated licensed nurses should have clarified Resident 86's Norco order dated 10/24/24 with the doctor. During a review of the facility's policy titled Pain-Clinical Protocol revision dated October 2022, the policy did not provide guidance related to clarifying pain medication orders.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to provide trauma-informed care (care that involves recognizing and responding to the effects of all types of traumas) to one of six sampled residents (Resident 294). This deficient practice had the potential for Resident 294 to experience re-traumatization that could lead to severe psychosocial harm and affect the resident's quality of life. Findings: A review of Resident 294's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included PTSD (PTSD, a disorder in which a person has difficulty recovering after experiencing a terrifying event), depression, and alcohol use. A review of Resident 294's Minimum Data Set (MDS, an assessment tool) dated 10/16/24 indicated Resident 294 had intact cognitive skills (the ability to think, remember, and reason). On 10/29/24 at 11:04 A.M., an interview was conducted with Resident 294. Resident 294 stated he was a military veteran and had been stationed in Iraq. Resident 294 stated he was diagnosed with PTSD. Resident 294 stated his trigger (something that causes a person to remember a previous traumatic event) was . anything wartime battle related .I freak out . On 10/30/24 at 9:32 A.M., an interview was conducted with CNA 21. CNA 21 stated she was Resident 294's assigned CNA. CNA 21 stated she was unaware Resident 294 had a diagnosis for PTSD. CNA 21 stated, . whatever trauma they had in their lives have triggers .we need to be aware of any triggers they may have. It could remind them of that traumatic experience . On 10/31/24 at 8:20 A.M., an interview was conducted with CNA 22. CNA 22 stated she had been Resident 294's assigned CNA .more than once since he was admitted . and was not aware of a PTSD diagnosis. According to CNA 22, it was important to know Resident 294's triggers, .because multiple things can happen . it could be dangerous for us. He could be physical, hands on if he gets triggered, depending on what his PTSD was . On 11/1/24 at 3:13 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important for staff to be informed of Resident 294's PTSD diagnosis. The DON stated .its important to avoid distress for the resident. If the resident experiences their trigger then they could experience psychological distress . The DON stated it was her expectation that staff provided trauma-informed care to residents. A review of the facility policy titled Trauma-Informed and Culturally Competent Care Level 3 revised August 2022 indicated its purpose was, .To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .

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	055114	A. Building B. Wing	11/01/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956 Based on interview and record review, the facility failed to ensure controlled medications (medications with high abuse potential) reconciled with the medication administration record (MAR) for one of three residents (Resident 86). This failure had the potential for drug diversion (the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use). Findings: According to the Admission record, Resident 86 was admitted to the facility on [DATE]. During a record review of Resident 86's Medication Administration Record (MAR), Resident 86 had an order for: Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth two times a day for pain management Start Date 09/11/2024 0900 [9 A.M.] (D/C Date (ending date) 10/23/2024 2046 [8:46 P.M.]. This same order was then restarted on 10/23/2024 at 2100 [9 P.M.] and D/C [discontinued] date of 10/24/2024 0857 [8:57 A.M.] when it was replaced with the order Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth as needed for Twice daily as needed for pain management. twice daily as needed for pain. Start date 10/24/2024 0900 [9 A.M.]. The MAR further indicated that the only medication given on 10/24/2024 was at 8:27 P.M. During a record review of Resident 86's Controlled Drug Record (a document where a licensed nurse signs, dates, and times when a narcotic is given to a resident), dated 10/8/2024, there was a dose signed out on 10/24/2024 at 9:00 A.M During an interview and concurrent record review on 11/1/2024 at 10:20 A.M., with Licensed Nurse 2 (LN 2), LN 2 stated the procedure for giving a controlled medication would be to check the MAR, the orders, the resident's pain level, enter it in the controlled drug record and the MAR. LN 2 stated Resident 86's MAR was blank on 10/24/24 at 9 A.M. LN 2 stated if it was not documented, then it could not be verified it was given to Resident 86. LN 2 reviewed Resident 86's progress notes and stated there was no documentation to indicate where the medication had gone. During an interview on 11/01/2024 at 2:35 P.M., with the Director of Nursing (DON), the DON stated after a medication was given it was documented in the MAR and signed off in the controlled drug record. The DON stated there was one missing dose on the morning of 10/24/24. The DON stated all doses must be accounted for and the records justified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7800 Parkway Drive LA Mesa, CA 91942	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy titled, Controlled Substances revised November 2022, the policy indicated that .3. Nursing staff count controlled medication inventory at the end of each shift, using these records (Records of personal access and usage; Medication administration records; Declining inventory records, Destruction, waste and return to pharmacy records) to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956 Based on interview and record review, the facility failed to ensure one resident (Resident 68) who received a psychotropic medication (a medication that affects brain activity associated with mental processes and behavior) had accurate monitoring for use of the medication. As a result of inaccurate monitoring, there was a potential the facility would not be able to determine if the medicine was effective or if a gradual dose reduction was beneficial which put Resident 68 at risk for receiving unnecessary psychotropic medication. Findings: According to the Admission record, Resident 68 was admitted on [DATE]. Resident 68's admitting diagnosis was unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture routine healing (a break in the hip joint that did not require surgery to heal). Resident 68 had a diagnosis of dementia (a long term condition that causes a decrease in brain function) and a diagnosis of depression (a mental health condition that impacts how a person feels, thinks, and functions). During a record review of the Order Summary Report dated 11/1/2024, the report indicated that Resident 68 was prescribed on 5/12/23, Trazodone HCL [antidepressant medication] oral Tablet 50 MG (Trazodone HCL): Give one tablet by mouth at bedtime for Major Depressive Disorder AEB [as evidenced by] Sleep Disturbances. The report further indicated that Resident 68 was on behavioral monitoring (sleep disturbances) for the use of Trazodone every shift starting on 9/17/24. During a record review of the October 2024 Antidepressant Monitoring Record for the use of Trazodone, Resident 68 was documented as having had sleep disturbances during the day shift (7 A.M. to 3 P.M.) 22 days and for 29 days on the P.M. shift (3 P.M to 11 P.M.). The record further indicated Resident 68 had no sleep disturbances during the night shift (11 P.M to 7 A.M.). During an interview on 11/1/2024 at 10:28 A.M., with Certified Nursing Assistant (CNA 11), CNA 11 stated the night shift reported that Resident 68 was up three to four nights a week. CNA 11 stated Resident 68 had memory issues but did not sleep during the day. CNA 11 stated Resident 68 was up and active during the daytime and participated in most everything. During an interview on 11/1/2024 at 10:35 A.M., with Resident 65 (Resident 68's roommate), Resident 65 stated, Resident 68 seems confused at night, sometimes staff comes in and talks to her. Sometimes they take her out in her wheelchair. Resident 65 further stated she had asked for a room change due to Resident 68 being awake at night. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview and record review on 11/1/2024 at 10:42 A.M., with Licensed Nurse (LN 11), LN 11 stated Resident 68 was up, alert, and awake in the daytime. LN 11 stated, I really don't see any sleeping during the day. LN 11 stated there were outbursts of crying and wanting to go home sometimes. LN 11 stated the behavior monitoring for Resident 68 was for sleep disturbance and not for signs of depression. LN 11 stated he should have answered, no sleep disturbance for day shift on the Antidepressant Monitoring Record. LN 11 stated Resident 68's monitoring for sleep disturbances was inaccurate. During an interview on 11/1/2024 at 11:15 A.M., with LN 2, LN 2 stated the monitoring record was used for each shift to see if a resident was having a certain behavior or issue. LN 2 stated for Resident 68, the monitoring was for sleep disturbances. LN 2 stated a yes would mean the staff saw a sleep disturbance and a no meant that they did not. LN 2 stated We would expect to see them [sleep disturbances] at night and not during the day. Maybe some during PM shift, but the record is opposite of that. That makes me believe the record is not accurate. LN 2 stated doctors use the record when they evaluate the medications, so if the data was not accurate then there was the potential for unnecessary medication. LN 2 stated The pharmacist uses the record too; the data is used to establish gradual dose reductions. If it is not accurate the resident might be getting an unnecessary medication or too much medication. During an interview on 11/1/2024 at 2:35 P.M., with the Director of Nursing (DON), the DON stated residents were monitored for the effects of medications and symptoms of concern. The DON stated a yes on the Antidepressant Monitoring Record would indicate they were showing sleep disturbances, a no would indicate that they were not. The DON stated monitoring should have been clear, so everyone saw the same thing. The DON stated the record helped the physician to determine if the medication was effective, so it needed to be accurate to prevent unnecessary medications. During a review of the facility policy titled, Psychotropic Medication Use revised July 2022, the policy indicated that .8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes .10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible 11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions) unless clinically contraindicated, in an effort to discontinue these medications .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview and record review, the facility failed to ensure food served was in a palatable (pleasant and appealing), flavorful manner that maintained the nutritional value of the menu items served. This failure had the potential to decrease residents' meal intake and contribute to weight loss. The facility census was 86. Cross-Reference F867 Findings: During a dining observation on 10/29/24 the following confidential resident food concerns occurred: - 8:26 A.M., did not like the food, bad taste. - 9 A.M., did not like food: processed meat, cold food, mashed vegetables, spicy dinner last night .lost weight per preference but also due to not liking the food . - 9:16 A.M., breakfast always scrambled eggs, cold food. - 9:21 A.M., food was always cold. - 9:32 A.M., food not good, no taste, sometimes cold. - 9:52 A.M., food had been cold. - 10:01 A.M., I can't identify it, I won't eat it. - 10:01 A.M., Food dried out, cooked twice, not up to temperature. - 10:46 A.M., food taste was not good. - 11:59 A.M., Food is always cold. - 11:59 A.M., food is terrible. - 11:59 A.M., Sometimes the meat is too salty. - 12:32 P.M., the food is kind of spicy and they know I don't like spicy, but they gave it to me anyway. - 3:59 P.M., provided thumbs down when asked about food. - 4:07 P.M., food tasteless. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a dining observation on 10/30/24 the following confidential resident food concerns occurred: -12:32 P.M., sauce tasted like plain tomato sauce. - 4:32 P.M., most of them complained about food. During a dining observation on 10/31/24 the following confidential resident food concerns occurred: - 8:57 A.M., My tray is always the last served and in fact one time they forgot my dinner and didn't eat till 11 P.M .Lunch the food was cold yesterday and its cold so often. Yesterday's meal looked like a few days or more. The day before they sprinkled chilli powder on my pasta it should be cooked with it not served as a condiment. The food yesterday was forgettable. - 12:04 P.M., Doesn't like the food. Maybe that's why I'm loosing weight. No alternatives. Never. Review of the facility's Resident Council meeting minutes dated May 2024, June 2024, July 2024 August 2024 and September 2024 the following dietary concerns were identified: - 5/23/24: less chicken, healthier options. - 6/6/24: too much chicken and dry, not liking food. - 7/5/24: Same complaint as in August with PB&J [peanut butter and jelly] and certain juice. - 8/1/24: Wanted different food items PB&J. - 9/5/24: Complaints regarding food. During an interview on 10/30/24 at 10:09 A.M., a group interview was conducted with the resident council president and members, in the activities dining room. The food concerns included: - doesn't want eggs and always gets them. - no consistency the meal is not the same day to day sometimes good then bad. - Food is delivered very late. - Food looks like skippy dog food. - Menu's are not followed. - No choice of the food get what you get. - can't identify what the food is most of the time. A review of the facility's lunch menu on 10/30/24 indicated Beef cubes with Mushrooms, Egg noodles, Seasoned Spinach, Tossed [NAME] Salad and Spiced Applesauce cake. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's document titled [Facility Name] Meal Times indicated, the last meal cart to be delivered for lunch was at 12:55 P.M., at the [NAME] 2 residential rooms (40-52) of the facility. During a test tray observation on 10/30/24 at 1:20 P.M., was conducted with the Registered Dietician (RD) and Dietary Supervisor (DS) after the last delivered lunch tray to room [ROOM NUMBER]. The pureed plate was observed with two similar colored light-yellow mashed food with one side covered with glossy yellow gravy, dark green mashed vegetable and a mashed brown meat covered with tomato like-red sauce. Both the RD and the DS stated the plate did not have separation to look palatable. The Regular textured meal contained noodles covered with a watered-down sauce-like consistency of chopped meat with mushroom and dark green watery spinach. The RD and DS stated that the pureed spinach tasted better than the regular texture meal. Lastly, the dessert tasted like a churro per the DS rather than an applesauce cake. During an interview on 11/1/24 at 10:20 A.M., was conducted with the DS. The DS stated that her expectations were that resident's meal trays to be delivered in a timely manner because the food quality could start to go down and temperatures could get colder. The DS stated consistency should be maintained and original as possible. The DS stated that she does not have a formal process to track down the test trays and that the pureed textured meals need to be more appealing. The DS stated they use already cooked meals at times as to why they do not add additional seasoning but stated recipes could be tweaked to taste better. The DS stated if residents are complaining about the taste of the food they could get upset and loose their appetite not to eat that could lead to weight loss. During an interview on 11/1/24 at 10:37 A.M., was conducted with the RD. The RD stated they follow their recipes but can't alter their recipes too much. The RD stated he conducts test trays monthly, but it would be subjective (own opinion). The RD stated, I think there could always be improvements without actually altering the menus and recipes by making small changes such as offering salt substitutes to their likings or preference. The RD stated that presentation for quality lead to decreased meal intake and therefore lead to decreased nutritional status, weight loss, and malnutrition (poor nutrition). The RD further stated his expectations was to have the resident food trays delivered on time and could affect the resident's appetite because of the inconsistency for the meal to come on time. The facility did not provide a policy and procedure for Test Trays/Meal Rounds. A review of the facility's policy and procedure titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .Prepared food will be sampled .Poorly prepared food will not be served-such food is to either be improved, prepared again, or replaced with an appropriate substitution. Note that increased amounts of herbs and spices (not salt) may be added, since potency of products may vary .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record reviews, the facility failed to provide food that accommodates resident's preferences for one of 20 residents (Resident 72) sampled. This failure had the potential for Resident 72 to experience poor meal intake and weight loss due to foods they do not like or tolerate. Findings: A review of Resident 72's Admission Record indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included a history of heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A record review of Resident 72's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 7/30/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 12 points out of 15 possible points which indicated Resident 72 had minimal cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 10/29/24 at 12:32 P.M., an observation and interview was conducted with Resident 72, in the dining room. Resident 72 had a plate with chopped chicken. Resident 72 stated the food is kind of spicy and they know I don't like spicy but they gave it to me anyway. Menu ticket did not indicate meats to be chopped. On 10/31/24 at 12:13 P.M., an observation and interview was conducted with Resident 72, in the dining room. Resident 72 had a plate with meat and gravy on the side in a small condiment plastic container. Resident 72 stated I don't like gravy, it says it on my dislikes. A review was conducted on 10/31/24 of Resident 72's ticket menu. Resident 72's ticket menu listed texture as Regular with no indication for chopped meats. Resident 72's dislikes listed gravy. On 11/1/24 at 10:11 A.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated Resident 72 should not have received a meal tray with the gravy because it was stated on his ticket menu. The DS also stated if the resident preferences are not being followed that this could lead to a resident to become upset and could lose weight from poor meal intake. On 11/1/24 at 10:37 A.M., an interview was conducted with the Registered Dietician (RD). The RD stated they (the facility) try to offer substitutes to a resident's liking or preference but can continue to improve and adapt to our residents. The RD further stated that it was important to make sure preference were being followed according to their likings to promote a better meal intake. The facility did not provide a policy and procedure for Menus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7800 Parkway Drive LA Mesa, CA 91942	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48263 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices in dietary services were maintained according to standards of practice when: 1. Two individual sized cereal containers were found on the floor under the food shelves of the dry pantry storage. 2. One large food can item was dented. 3. Food boxes stored above the red line (18 inch) mark from the ceiling from fire sprinkler clearance. 4. Five food seasonings was previously used without an opened date. 5. One dish machine did not have a proper air gap system to adequately prevent backflow of contaminated fluids. 6. A red sanitation bucket was placed on top of a food production table. These failures had the potential to cause widespread food borne illness among all 86 residents who receive food from the kitchen. Findings: 1. During the initial kitchen tour on 10/29/24 at 8:38 A.M., an observation was conducted with the Dietary Supervisor (DS). Upon entry there were two shelves on the left of the dry storage food pantry with brown boxes on the top shelf and food items stored on each shelf. In the middle of the two shelves there were two red empty crates on the floor flipped upside down. Between the middle shelves by the red crates on the floor was an individual sized cereal container. To the center of the dry food pantry at one arms width away from the middle shelves was the canned food shelf. Below the canned food shelf a second individual sized cereal container was seen on the floor. During an interview on 10/29/24 at 8:56 AM with the DS. The DS stated that the two cereal containers should not be on the floor. The DS stated food items should be stored on the shelves and not the floor to prevent contamination and prevent pest infestation (large number of animals and insects that carry disease). A review of the facility's policy and procedure titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .All food and food containers are to be stored 6 (inches) off the floor and on clean surfaces in a manner that protects from contamination . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview on 10/29/24 at 8:53 A.M., with the Dietary Supervisor (DS) in the kitchen dry storage food pantry, a large six lb (pound) 15 oz (ounce) tomato paste was seen dented on the side of the front label stored on the shelf with the other canned goods. The DS supervisor stated dented cans should not be stored with the other canned goods and should be discarded. The DS stated dented cans should not be used because of the health risk of botulism (a rare but serious illness caused by a toxin that attacks the body's nerves). A review of the facility's policy and procedure titled FOOD STORAGE-DENTED CANS dated 2023, indicated .cans with side seam dents, rim dents or swells shall not be retained or used by the facility. 3. During an observation and interview on 10/29/24 at 8:58 A.M., with the Dietary Supervisor (DS) in the dry storage food pantry, multiple brown boxes were stacked on top of the food shelves which was above the red line marked on the walls of the food pantry. Above the tallest box was a fire sprinkler which measured about two hands vertically apart from each other. The DS stated the brown boxes contained food and that the boxes should not have passed the red line mark and stored properly. The DS stated that it was a fire hazard and that the sprinkler would not work efficiently because of the boxes to close to it. During an interview on 10/30/24 at 12:09 P.M., with the Registered Dietician (RD), the RD reviewed the photos of the stacked brown boxes in the dry storage food pantry. The RD agreed that the boxes should not be stacked passed the red line and close to the fire sprinkler. The RD stated it was important not to pass the red line since this marked the 18 inch range of the ceiling to pose a fire risk from the sprinkler that could potentially damage food items in the dry storage food pantry. A review of the facility's policy and procedure titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .Store all food and supplies at least 18 from the ceiling for the fire sprinkler clearance .Remove foods from the packaging boxes upon delivery. This is to minimize pests . According to the California Building code 2019 Title 24, section 315.3.1 Ceiling clearance, Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or not less than 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. 4. During an observation and interview on 10/29/24 at 8:53 A.M., with the Dietary Supervisor (DS) in the dry storage food pantry there were five food seasonings that were previously used without an opened date. The food seasonings included: - Table grind pepper: contained approximately 75% used seasoning - Whole basil leaves: contained approximately 25% used seasoning - Ground white pepper: contained approximately 20% used seasoning - Tarragon leaves: contained approximately 25% used seasoning - Lemon pepper: approximately 30% used seasoning (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7800 Parkway Drive LA Mesa, CA 91942	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DS agreed that the five seasonings were used because there was no protective seal inside the inspected seasoning when the caps were flipped and that the seasonings were not fully filled. The DS stated opened dates should be labeled for the five seasonings. The DS stated the five seasonings needed to be labeled properly with an opened date because the shelf life of an unopened seasoning versus an opened seasoning could overtime loose the efficiency and taste. A review of the facility's policy and procedure titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .Bins/Containers are to be labeled, covered and dated . 5. During a kitchen observation and interview on 10/29/24 at 9:14 A.M., with the Maintenance Assistant (MTA) and the Dietary Supervisor (DS) the low temperature dishwashing machine was piped directly through a food production sink pipe underneath the low temperature dishwashing machine conveyor. The MTA stated the black polyvinyl (PVC: made of plastic or vinyl) pipe from the low temperature dishwashing machine did not have an air gap and was pushed down into the floor sink drain. The MTA stated an air gap between the PVC and the floor sink drain needed to be raised to prevent back flow. The MTA stated it was important to have an air gap to prevent contamination from the water to spread all over the floor in the kitchen. The DS stated it was important to have an air gap to prevent the backflow of contaminated water. During an interview on 10/30/24 on 12:09 P.M., with the Registered Dietician (RD), the RD reviewed the photos of air gaps by the low temperature dish washing machine. The RD stated it was important to have an air gap space between the floor sink drain and the pipes to prevent the backflow of contaminated sewage and prevent contamination of kitchen surfaces. A review of the facility's policy and procedure titled ACCIDENT PREVENTION-SAFETY PRECAUTIONS dated 2023, indicated .An air gap between the water supply inlet (drainpipe) and the flood level rim of the plumbing fixture (floor sink drain), equipment or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. According to the 2022 Federal FDA Food Code, section 5-202.13 titled Backflow Prevention, Air, .An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, Or nonfood EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). 6. During a kitchen observation and interview on 10/29/24 at 9:24 A.M. was conducted with the Dietary Assistant (DA) 1 and the Dietary Supervisor (DS) by the food preparation area. During the interview with DA 1 the DS translated in Spanish regarding the observation of a red sanitizer bucket on top of the food preparation table between a toaster oven and the steam table. DA 1 stated she had put the red sanitizer bucket on top of the food preparation table to clean the area in preparation for lunch trays. DA 1 stated it should not be on top of the table because it can contaminate the food that gets prepared on the table. The DS stated the chemicals in the red sanitation bucket can cross-contaminate with the chemicals on to the food and should not be placed in areas where food are prepared to prevent food-borne illnesses. A review of the facility's policy and procedure titled STORAGE OF FOOD AND SUPPLIES dated 2023, indicated .Do not use cleaning products or sanitizer in the food preparation or food storage areas in a way that could result in contamination of exposed food items .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7800 Parkway Drive LA Mesa, CA 91942	

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48263 Based on observation, interview, and record review, the facility failed to ensure outdoor facility garbage and refuse (recyclable and non-recyclable trash) was not overflowing and was secure with the dumpster's lids closed, for one of three facility dumpsters located outside the kitchen by the parking lots. This had the potential for an unsafe environment for the residents and visitors due to possible pest infestation and spread of diseases in the facility. Findings: On 10/29/24 at 9:30 A.M., an observation and interview was conducted with the Dietary Supervisor (DS). Dietary Aide (DA) 2 was observed pushing a blue wheeled kitchen trash barrel with no lid outside the kitchen towards the facility's garbage and refuse area. The three blue facility dumpsters were located by the parking lot area outside of the kitchen. The first dumpster did not have one of the two lids securely closed and the third dumpster had several bags of trash overflowing to the top of the dumpster that prevented the lids to fully close and secured. The DS stated DA 2 should have had a lid on the kitchen trash barrel while wheeling it to the dumpster. The DS stated that the third dumpster should not be overflowing because it won't be able to fully close all the way and that all the lids for the dumpsters should be closed and secured. The DS stated it was important to secure the dumpsters because this can attract pests and be a problem for the facility. A review of the facility's policy and procedure titled DISPOSE OF GARBAGE AND REFUSE dated November 2017, indicated .Garbage and refuse containers are maintained in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids covered . According to the 2022 Food and Drug Administration Food Code, section 5-501.15 titled Outside Receptacles, .Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055114	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Nursing Center	7800 Parkway Drive LA Mesa, CA 91942

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to ensure one of five residents (Resident 15) reviewed for weight loss had a completed Interdisciplinary Note and SBAR (Situation, Background, Assessment, and Recommendations) Communication Form in the resident's electronic health record (EHR). This deficient practice had the potential for Resident 15's condition not to be communicated to all healthcare providers. Findings: According to the Admission Record, Resident 15 was admitted on [DATE] with diagnoses that included protein-calorie malnutrition and type 2 diabetes. On 10/29/24, a review of Resident 15's EHR was conducted. Resident 15's Interdisciplinary (IDT) Note indicated resident had an unplanned weight loss of 18.3 pounds in one month. The IDT note indicated an effective date of 10/4/24. The IDT note indicated Late Entry and was entered into Resident 15's chart on 10/29/24. On 10/31/24 at 2:41 P.M., an interview was conducted with the Registered Dietitian (RD). The RD stated Resident 15's weight loss was considered a significant weight loss. The RD stated the IDT note .should have been entered [into Resident 15's records] as soon as possible, for greater communication and access . The RD stated it was important to update Resident 15's medical record timely .so the weight change could be reviewed by the team .to prevent more weight loss to occur . On 11/1/24 at 2:52 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the IDT note was late, and it should have been entered into Resident 15's chart the day of the IDT meeting. The ADON further stated there should have been an SBAR Communication note because Resident 15's weight loss was a change in condition. The ADON stated, There should have been an SBAR because of the weight loss .we have to be more proactive with that .she's at risk . On 11/1/24 at 3:34 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for staff to document as soon as possible. The DON stated, .it's important to document in a timely fashion because its evidence that you did something for the resident. If its not documented then its not done . A review of the facility's policy titled Change in a Resident's Condition or Status dated February 2021 indicated, .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record reviews, the facility failed to assure the full understanding of an arbitration agreement was explained to three reviewed residents (Resident 68, Resident 72, and Resident 34) when: 1. Resident 68 entered into a legal agreement when they did not have the capacity to understand what they were signing. 2. Resident 72's family member who was not the responsible party (RP) or legal representative signed the agreement without explaining to Resident 72 what the agreement was about. 3. Resident 34 was not given a copy of the signed arbitration agreement and did not fully understand that they had 30 days from the date they signed to cancel the agreement. As a result, the residents (Resident 68, Resident 72 and Resident 34) entered into a legal agreement when they did not fully understand what they were signing and posed the risk for the residents to give up their judicial (judgments made in a court) rights for any medical malpractice. Findings: 1. A review of Resident 68's Admission Record indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included a history of dementia (a progressive state of decline in mental abilities). A record review of Resident 68's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 8/8/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 7 points out of 15 possible points which indicated Resident 68 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 68's electronic clinical chart (ECC) under the MISC (miscellaneous) tab titled, Comprehensive assessment dated [DATE] completed by Resident 68's medical doctor (MD) indicated .This resident does NOT have the capacity to understand and make decisions . and was checked under conservatorship (when a judge appoints another person to act or make decisions for the person who needs help). A record review of Resident 68's document titled, Arbitration Agreement indicated resident signed the document on 5/10/23. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 8:40 A.M., a concurrent interview, and record review was conducted with Admission Coordinator (AC) 1. AC 1 stated that their process with new admissions was to have residents sign all admissions paperwork within 72 hours to include the Arbitration Agreement as part of the admission's packet and was a basis to be admitted . AC 1 stated she did not have a clinical background to determine if Resident 68 was completely there or had the capacity to make decisions given her diagnosis of dementia. AC 1 conducted a record review on Resident 68's ECC and confirmed that Resident 68 had a diagnosis of Dementia and that an MD Comprehensive Assessment was signed on 6/1/23 that indicated Resident 68 did not have the capacity to understand and make decisions. AC 1 stated Resident 68's conservator should have been notified regarding the Arbitration Agreement in order for them to cancel the agreement within 30 days and found no documentation to support notifying or giving Resident 68 or conservator a copy of the Arbitration Agreement. AC 1 stated that an Arbitration Agreement if it was signed means that any complaints or issues from the facility that they need to work out with the facility and prevents them from taking the facility to court. On 11/1/24 at 8:40 A.M., a concurrent interview, and record review was conducted with the Admissions Director (AD). The AD stated, normally they [The Facility] we ask them [Hospital admission's team] who is able to make decisions. The AD conducted a record review on Resident 68's ECC and was unable to find documentation from the hospital of what was discussed. The AD stated for cognitively (mental process to understand and process information) impaired residents they would call family members or look at the Physicians Orders for Life Sustaining (POLST) to determine if it was signed. The AD stated she was not clinical but acknowledged that a MDS was conducted on 5/8/23 that determined Resident 68 had an impaired cognitive deficit two days before Resident 68 signed the agreement on 5/10/23. The AD conducted a record review on Resident 68's ECC that indicated Resident 68 had a diagnosis of dementia and that a MD Comprehensive Assessment on 6/1/23 determined that Resident 68 did not have the capacity to understand and make decisions. The AD stated normally we only do once from my understanding we would never had to re-do an arbitration. Once they sign the arbitration agreement, they opt out of filing legal action against the facility. The AD stated that her expectations was for the admissions team to wait for a family member or conservator to sign the Arbitration Agreement. The AD stated there was no documentation to support that an Arbitration Agreement was given to Resident 68 or the conservator notified. On 11/1/24 at 11:46 A.M., an interview, and record review was conducted with the Director of Nursing (DON), in the DON's office. The DON conducted a record review on Resident 68's ECC that indicated Resident 68's first MDS was conducted on 5/8/23 with a BIMS score of 7/15 points that had not changed from the most current MDS on 8/8/24 that indicated she had severe cognitive impairments since being admitted to the facility. The DON stated the admission coordinators should have checked with the licensed nurses (LN) to determine if Resident 68 had the capacity to understand the Arbitration Agreement prior to having Resident 68 sign the document on 5/10/24 which was supported by the MD Comprehensive Assessment on 6/1/23 that determined Resident 68 did not have the capacity to consent. The facility did not provide a policy and procedure for Arbitration Agreements. 2. A review of Resident 72's Admission Record indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included a history of heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7800 Parkway Drive LA Mesa, CA 91942	

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 72's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 7/30/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 72 had minimal cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 10/30/24 at 10:09 A.M., an interview was conducted with Resident 72, in the dining room during a resident council meeting. Resident 72 stated when he got to the facility the admission coordinators had a family member who was not Resident 72's responsible party (RP: someone appointed to make health care decisions) or power of attorney (POA: a legal document signed to act on behalf of a resident) sign documents during his admission to the facility. Resident 72 stated he was his own RP and concerned if an Arbitration Agreement was signed this would not have represented his decision to sign the document. Resident 72 stated the Arbitration Agreement was never explained to him and was not given a copy to know that he was able to cancel the Arbitration Agreement within 30 days. On 11/1/24 at 8:51 A.M., an interview and record review was conducted with the Admissions Coordinator (AC) 1. AC 1 stated that Resident 72's arbitration agreement was signed on 10/27/23 by a family member. AC 1 stated that Resident 72 was his own RP and was unsure if a copy was given to him. AC 1 stated that there was no documented evidence the Arbitration Agreement was explained to Resident 72 or a copy of the agreement was provided. On 11/1/24 at 9:10 A.M., an interview and record review was conducted with the Admissions Director (AD). The AD stated normally we only do once from my understanding we would never had to re-do an arbitration. Once they [residents] sign the arbitration agreement, they opt out of filing legal action against the facility. The AD stated unless a resident did not have the capacity to sign the agreement then a family member would need to be contacted on behalf of the resident to sign the agreement. The AD stated there was no documentation that an Arbitration agreement was explained or that a duplicate copy was given to Resident 72. The facility did not provide a policy and procedure for Arbitration Agreements. 3. A review of Resident 34's Admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses which included a history of spinal stenosis (is the narrowing of the spine which puts pressure on the spinal cord & nerves & can cause pain). A record review of Resident 34's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 8/8/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 34 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 10:09 A.M., an interview was conducted with Resident 34, in the dining room during a resident council meeting. Resident 34 stated she did not fully understand what an Arbitration Agreement was and was not given a copy of the agreement to thoroughly read it. Resident 34 stated she had filled out many forms for admissions and may have been out of it when she signed the Arbitration Agreement. Resident 34 stated if she had received a copy of the Arbitration Agreement that she would have had time to read through it and have a better understanding to cancel the agreement within 30 days of her signing the agreement. Resident 34 stated if she fully understood what she was signing that she would not have signed the Arbitration Agreement to give up her legal rights to go to court against the facility. On 11/1/24 at 8:51 A.M., an interview and record review was conducted with the Admissions Coordinator (AC) 1. AC 1 stated that Resident 34's arbitration agreement was signed on 8/25/22 by Resident 34. AC 1 stated that Resident 34 was her own RP. AC 1 stated that there was no documented evidence the Arbitration Agreement was explained to Resident 34 or a copy of the agreement was provided. On 11/1/24 at 9:10 A.M., an interview and record review was conducted with the Admissions Director (AD). The AD stated normally we only do once from my understanding we would never had to re-do an arbitration. Once they [residents] sign the arbitration agreement, they opt out of filing legal action against the facility. The AD stated unless a resident did not have the capacity to sign the agreement then a family member would need to be contacted on behalf of the resident to sign the agreement. The AD stated there was no documentation that an Arbitration agreement was explained or that a duplicate copy was given to Resident 34. The facility did not provide a policy and procedure for Arbitration Agreements.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46235 Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify areas of improvement and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility), complaints identified in resident council meetings and by surveyors during the recertification survey concerning food served to the residents. Cross reference F804 and F806 This failure resulted in unresolved issues affecting the residents' quality of life. Findings: On 11/1/24 at 4:20 P.M. an interview with the Director of Nurses (DON) and a review of the QAPI program was conducted. The DON stated the issues discussed in the QAPI meetings were falls, diabetic care, inaccurate orders from the hospital, unsafe discharges, and weight loss. The DON stated the issues in the resident council meetings pertaining to food from the months of May, June, July, August, and September 2024 were not addressed in the QAPI meetings. The DON stated she reviewed the minutes form resident council meetings and the Administrator distributed resident concerns to the assigned disciplines. The DON stated the food issues should have been brought up in the QAPI meetings. During a review of the facility's undated policy and procedure (P&P) titled, Quality Assessment & Assurance, the P&P indicated .The committee must . coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program .Develop and implement appropriated plans of action to correct identified quality deficiencies .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47956 Based on observation, interview, and record review the facility failed to ensure infection control procedures were followed when: 1. Certified Nursing Assistant (CAN) 11 provided care to a resident, Resident 65, who was on Enhanced Barrier Precautions (EBP-stronger infection control requirements requiring gowns and masks in addition to gloves) without wearing appropriate personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). 2. Licensed Nurse (LN) 4 did not perform hand hygiene (the practice of cleaning hands to remove germs, dirt, or other harmful substances) consistently after removing her gloves. In addition, LN 4 wore bandages on both hands and fingertips which prevented her hands from being fully cleaned. These failures had the potential to result in the spread of infection among residents, staff, and visitors. FINDINGS: 1. During an observation on 11/1/2024, at 10:25 A.M. in the hallway outside of room A, CAN 11 was observed transferring (assisting a patient with movement) Resident 65 from bed to wheelchair. The sign outside of Resident 65's room indicated that Resident 65 was on EBP. CAN 11 was observed not wearing a gown or mask during the transfer. During an interview on 11/1/2024 at 10:28 A.M., with CAN 11, CAN 11 stated Resident 65 just came back from a shower and he dressed the resident. CAN 11 stated, I should have worn a gown. The sign outside Resident 65's room was observed with CAN 11, it indicated EBP must be used with transfers. CAN 11 stated, The staff member could get sick, or they could get other residents sick. During an interview on 11/1/2024 at 10:43 A.M., with the Infection Preventionist (IP), the IP stated staff have been in-serviced on EBP. The IP stated if touching Resident 65, the staff must wear EBP and that was not done to my expectation. During an interview on 11/1/2024 at 2:35 P.M., with the Director of Nursing (DON), the DON stated there were signs and supplies outside of the rooms with EBP requirements. The DON stated every staff member should be aware of the expectations and the potential of spreading infections to the staff and other residents. The DON stated it was not acceptable for any staff member not to follow EBP. During a review of the facility's policy titled, Enhanced Barrier Precautions dated August 2022, the policy indicated Enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: a. dressing b. bathing/showering c. transferring (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication pass observation on 10/31/2024, at 8 A.M., Licensed Nurse 4 (LN 4) was observed preparing medications for Resident 57 who was on EBP. LN 4 was observed performing hand hygiene (washing hands) with adhesive bandages on both hands and fingertips. LN 4 then put on gloves and prepared Resident 57's medications for administration via G-tube (GT- tube inserted in abdominal wall in the stomach). LN 4 did not perform hand hygiene between several glove changes that occurred during medication preparation. After preparing medications, LN 4 removed the gloves and washed hands with soap and water. LN 4 put on another pair of gloves to give Resident 57 the medications. After giving the medications, LN 4 removed the gloves and washed hands using soap and water. LN 4 then proceeded to the next resident's room to give medications without removing her wet bandages. During an interview on 10/31/2024 at 2:33 P.M., with LN 4, LN 4 stated My hands are cracked from the gel sanitizer. That's why I have the band-aids on them. LN 4 stated she washed her hands at the beginning and at the end of care. LN 4 stated she should have also performed hand hygiene each time she removed her gloves. LN 4 stated the band aids get wet and can carry infection and it was not good infection control. During an interview on 10/31/2024 at 2:50 P.M., with the Infection Preventionist (IP), the IP stated the expectation was to use the gel sanitizer when not washing with soap and water. The IP stated band aids cannot be used because they would harbor bacteria and the skin would become macerated (wet skin). The IP stated the expectation was to wash hands before and after glove use to reduce potential cross contamination. During an interview on 10/31/2024 at 3:55 P.M., with the Director of Nursing (DON), the DON stated staff must glove and do hand hygiene using the gel sanitizer. The DON stated staff who could not use the gel, must wash with soap and water. The DON stated staff should not have band aids on their hands. The DON stated wet band aids would be a source for infection. The DON stated all staff should be following the hand hygiene policy. During a review of the facility's policy titled, Handwashing/Hand Hygiene revised on October 2023. The policy indicated .1. Hand hygiene is indicated .g. immediately after glove removal .5. The use of gloves does not replace hand washing/hand hygiene.