STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055298	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Skilled Nursing	325 Potter Street Fallbrook, CA 92028

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46659 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's call light was placed within reach for 1 (Resident #1) of 19 sampled residents. Findings included: A facility policy titled, Strategies for Reducing the Risk of Falls revised 03/2018, indicated Call light within resident's reach. An Admission Record indicated the facility readmitted Resident #1 on 11/21/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of personal history of traumatic brain injury. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. During an observation on 04/29/2025 at 2:42 PM, Resident #1 was observed in bed and their call light was noted on the floor behind the resident's bed. During an interview on 04/29/2025 at 3:29 PM, Licensed Vocational Nurse #5 stated Resident #1's call light should be close to them. During a concurrent interview and observation on 04/30/2025 at 11:40 AM, Resident #1 was observed up in their wheelchair next to their bed in their room and their call light was noted on their bed. Resident #1 shook their head in a no motion when asked if they could reach their call light. During a concurrent observation and interview on 04/30/2025 at 12:22 PM, Certified Nursing Assistant (CNA) #7 stated she brought Resident #1 back to their room and placed the resident next to their bed. CNA #7 stated she placed the resident's call light on their bed, but she should have placed the call light near the resident. CNA #7 observed Resident #1's call light on their bed and stated the resident would not be able to reach the call light. CNA #7 then moved the resident's call light within their reach. During an interview on 05/01/2025 at 12:42 PM, the Director of Nursing stated she expected the staff to make sure a resident's call light was within reach of the resident at all times. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 1:23 PM, the Administrator stated he expected the staff to make sure a resident's call light was within reach of the resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 39714 Based on record review and interview, the facility failed to ensure a Level I preadmission screening and resident review (PASARR) was completed prior to admission for 1 (Resident #8) of 5 sampled residents reviewed for PASARR. Findings included: An Admission Record indicated the facility admitted Resident #8 on 01/07/2021. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2025, revealed Resident # 8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident had active diagnoses to include depression and schizophrenia. Resident #8's Care Plan Report included a focus area initiated 03/03/2025, that indicated the resident had a nutritional problem or the potential for a nutritional problem related to diagnoses to include dementia, schizophrenia, and major depressive disorder. Resident #8's medical record revealed no evidence to indicate a Level I PASARR had been completed. During an interview on 05/01/2025 at 11:13 AM, the Business Office Manager (BOM) stated she was responsible for making sure the PASARR was completed and accurate. The BOM stated Resident #8 should have had a Level I and Level II PASARR due to their mental illness diagnoses. During an interview on 05/01/2025 at 12:41 PM, the Director of Nursing (DON) stated the BOM was responsible for ensuring the PASARR was completed. Per the DON, Resident #8 should have had a Level I completed and the resident should have been referred for a Level II. During an interview on 05/01/2025 at 1:23 PM, the Administrator stated he expected the PASARR to be completed timely.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46659 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's fingernails and toenails were kept cleaned and trimmed for 3 (Residents #1, #23, and #40) of 4 sampled residents reviewed for activities of daily living (ADL). Findings included: A facility policy titled, Activities of Daily Living (ADLs), Supporting revised 03/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. An Admission Record indicated the facility readmitted Resident #1 on 11/21/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of personal history of traumatic brain injury. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for ADLs. Resident #1's Care Plan Report included a focus area care initiated 03/04/2025, that indicated the resident had an ADL self-care performance deficit related to activity intolerance and impaired balance. Interventions directed staff to check the resident's nail length and trim and clean on bath day and as necessary (initiated 03/04/2025). During an observation on 04/28/2025 at 10:25 AM and 04/29/2025 at 11:41 AM, Resident #1 was noted to have long fingernails on both hands. During a concurrent observation and interview on 04/29/2025 at 2:42 PM, Certified Nursing Assistant (CNA) #1 stated trimming a resident's nails was a part of the provision of ADL care. CNA #1 stated Resident #1 was dependent on staff for nail care. CNA #1 observed Resident #1's fingernails and stated the resident's fingernails needed to be trimmed. During an interview on 04/29/2025 at 3:13 PM, Licensed Vocational Nurse (LVN) #2 stated Resident #1 required staff to keep their nails trimmed and cleaned. Per LVN #2, Resident #1's fingernails were long and needed to be trimmed. During an interview on 04/30/2025 at 12:07 PM, Registered Nurse #3 stated nurses were supposed to trim a resident's fingernails and Resident #1 was dependent on staff for their personal hygiene care. 2. An Admission Record indicated the facility readmitted Resident #23 on 09/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and end stage renal disease. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/2025, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with bathing and personal hygiene. Resident #23's Care Plan Report included a focus area care initiated 09/04/2024 and revised 02/04/2025, that indicated the resident had an ADL self-care performance deficit related to a right, above the knee amputation, a diagnosis of dementia, and the disease process of end stage renal disease. Interventions directed staff to check the resident's nail length and trim and clean on bath day and as necessary (initiated 09/04/2024). During a concurrent observation and interview on 04/28/2025 at 10:43 AM, Resident #23 had dirty fingernails and stated they would like staff to keep their fingernails trimmed and cleaned. During a concurrent observation and interview on 04/29/2025 at 2:45 PM, Certified Nursing Assistant (CNA) #1 stated trimming a resident's nails was a part of the provision of ADL care. CNA #1 stated Resident #23 was dependent on staff for nail care. CNA #1 observed Resident #23's fingernails and stated the resident's fingernails needed to be trimmed and cleaned. During a concurrent observation and interview on 04/29/2025 at 3:00 PM, Licensed Vocational Nurse (LVN) #4 stated the CNAs normally trimmed a resident's fingernails. LVN #4 observed Resident #23's fingernails and confirmed the resident had long, dirty fingernails that needed to be trimmed and cleaned. During a concurrent observation and interview on 04/30/2025 at 10:38 AM, Resident #23 had long, dirty fingernails and stated they liked to keep their nails cleaned and trimmed. During an interview on 04/30/2025 at 12:07 PM, Registered Nurse #3 stated nurses were supposed to trim a resident's fingernails and Resident #23 was dependent on staff for their personal hygiene care. 3. An Admission Record indicated the facility readmitted Resident #40 on 06/12/2023. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2025, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance with bathing and personal hygiene. Resident #40's Care Plan Report included a focus area initiated 09/16/2024 and revised 03/05/2025, that indicated the resident had a potential for actual impairment to skin integrity related to fragile skin and incontinence. Interventions directed staff to keep the resident's fingernails short (initiated 09/16/2024). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 04/28/2025 at 12:56 PM, Resident #40 stated they needed to have their toenails trimmed and they had not been trimmed in a long time. Resident #40's toenails were long and curled and their fingernails were long. Resident #40 stated they liked long nails, but not long and jagged and that no one had ever offered to trim their nails. During a concurrent observation and interview on 04/29/2025 at 2:45 PM, Certified Nursing Assistant (CNA) #1 stated CNAs trimmed a resident's fingernails but not their toenails. CNA #1 stated Resident #40's fingernails needed to be filed and trimmed to prevent the resident from scratching themselves. During an interview on 04/29/2025 at 3:05 PM, Licensed Vocational Nurse (LVN) #2 stated after observing Resident #40's feet that the resident did need to have their toenails trimmed and it looked as though the resident had not had their toenails trimmed in a while. Per LVN #2, Resident #40's fingernails were jagged and needed to either be trimmed or filed to prevent the resident from scratching themselves. During an interview on 04/29/2025 at 3:25 PM, LVN #5 stated the CNAs should inform a nurse when a resident's toenails needed to be trimmed. Per LVN #5, the CNAs should trim a resident's fingernails. LVN #5 stated it was very important for a resident to have their nails trimmed so they would not scratch themselves. LVN #5 observed Resident #40's fingernails and stated the resident's fingernails were jagged and their toenails needed to be trimmed by a podiatrist. LVN #5 stated Resident #5 was dependent on staff for their personal hygiene care. During an interview on 04/30/2025 at 12:07 PM, Registered Nurse #3 stated nurses were supposed to trim a resident's fingernails and Resident #40 was dependent on staff for their personal hygiene care. During an interview on 05/01/2025 at 12:42 PM, the Director of Nursing stated she expected the staff to keep a resident's fingernails trimmed and cleaned. During an interview on 05/01/2025 at 1:23 PM, the Administrator stated he expected the staff to keep the residents nails trimmed and clean.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39714 Based on observation, interview, and facility policy review, the facility failed to ensure leftover and opened food items were labeled and dated when placed in the refrigerator. This deficient practice had the potential to affect all residents who received food from the kitchen. Findings included: 1. An undated facility policy titled, Leftover Foods indicated, Policy: Leftover foods will be stored and served in a safe manner. Procedure: Leftover foods are those that have been prepared for a meal and not served. 1. Storage of leftovers b. Label and date. During an observation of the reach-in refrigerator on 04/29/2025 at 11:14, there were two plates that contained a hamburger and French fries and one place that contained a pureed hamburger and pureed French fries that were not labeled or dated. The Dietary Manager stated the plates should be labeled and dated and that he would discard them now. 2. An undated facility policy titled, Foods Brought by Family /Visitors indicated, 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date. During an observation of the nourishment refrigerator on Station 1 on 04/29/2025 at 11:22 AM, there was an empty drink bottle, a box of opened strawberry snack cakes, and an opened bottle of a sports-themed beverage that were not labeled or dated. The Dietary Manager (DM) stated those items should not be in the refrigerator as they looked to belong to staff and this was the residents' refrigerator. The DM stated the items should be dated and labeled and he would discard them. During an interview on 05/01/2025 at 9:45 AM, Certified Nursing Assistant (CNA) #9 stated staff were not allowed to use the residents' refrigerator for personal use. CNA #9 stated all food items were to be labeled and dated when placed in the refrigerator. During an interview on 05/01/2025 at 10:16 AM, Licensed Vocational Nurse #11 stated that staff were not allowed to utilize the residents' refrigerators and that all food items should be labeled, dated, and discarded after 72 hours. During an interview on 05/01/2025 at 10:24 AM, Registered Nurse #3 stated the CNAs and nurses were responsible for checking the refrigerator daily to ensure food items were properly labeled and dated. During an interview on 05/01/2025 at 12:41 PM, the Director of Nursing (DON) stated the facility had a resident only refrigerator on each nursing station for resident use only. The DON stated that it was the nursing staff responsibility to ensure all food items were properly labeled, dated and removed after 72 hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/01/2025 at 1:23 PM, the Administrator stated all food items should be labeled and dated.

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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. 52066 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's catheter tubing and privacy bag were kept off the floor for 1 (Resident #14) of 3 sampled residents reviewed for urinary catheters. Findings included: A facility policy titled, Catheter Care, Urinary revised 09/2014, indicated, 3b. Be sure the catheter tubing and drainage bag are kept off the floor. An Admission Record indicated the facility admitted Resident #14 on 11/14/2012. According to the Admission Record, the resident had a medical history that included a diagnosis of epilepsy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/2025, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident had an indwelling catheter. Resident #14's Care Plan Report included a focus area revised 01/10/2025, that indicated the resident had a potential for actual impairment due to skin integrity related to fragile skin, diagnoses, seizure, incontinence, and the use of an indwelling urinary catheter. During an observation on 04/28/2025 at 10:37 AM, Resident #14's catheter was noted in a privacy bag, which was noted on the floor. During an observation on 04/28/2025 at 2:07 PM, Resident #14 was in bed and their urinary catheter tubing was noted on the floor. During an observation on 05/01/2025 at 8:56 AM, Resident #14's catheter was in a privacy bag that was noted lying on the floor beside the resident's bed. During an observation on 05/01/2025 at 9:27 AM, a certified nursing assistant (CNA) entered Resident #14's room to remove their breakfast tray. Resident #14's catheter was in a privacy bag that was lying on the floor beside the resident's bed. The CNA did not remove the resident's catheter privacy bag from off the floor. During an interview on 05/01/2025 at 12:41 PM, the Administrator stated staff were trained and expected to know how to care for and maintain a resident's urinary catheter.