STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to provide a comfortable temperature environment for five of seven residents (Residents 3, 4, 5, 6, and 7) interviewed during an air conditioning (AC) malfunction. In addition, the facility failed to document and maintain a temperature log as a proactive maintenance tool. As a result, temperatures were not checked during the AC failure. These failures had the potential to affect the resident ' s comfort, health, and physical well-being related to the building ' s warm internal temperature. Findings: On 8/21/24, an unannounced visit was made to the facility. On 8/21/24 at 10:35 A.M., during a tour of the west/south hallway the wall thermostat indicated a temperature of 79 degree Fahrenheit (F). The director of maintenance (DM) was not available for interview. A concurrent observation of the west/south hallway thermostat and interview with the maintenance aide (MA) was conducted on 8/21/24 at 10:39 A.M., The MA stated the air conditioner (AC) on the (west/south) unit stopped working two days prior. The MA stated that an AC company came out yesterday (8/20/24) and again that morning (8/21/24) and determined that parts were needed. Invoices were provided as proof. The MA stated the interior temperature could not go above (exceed) 79 degrees, per Federal regulation (Federal regulation requires temperatures must be maintained between 71 F and 81 F.) The MA did not know how long it would take for the repair, because he first needed permission from the Administrator, who was currently on vacation. The MA was asked about using the large portable AC unit that was observed at the end of the hallway. The MA stated he did not have the required hoses for the AC unit, and he would need to order them, after obtaining permission from the Administrator. The MA stated that 12 stand-up fans were ordered last week, but the fans had not yet arrived. Interviews were conducted randomly, with residents in the west/south hallway: (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: 055322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Resident 3 was admitted to the facility on [DATE], with diagnoses which included fracture of left side ribs, per the facility ' s Admission Record. Resident 3's Minimum Data Set, (MDS- a clinical assessment tool), dated 8/8/24, listed a cognitive score of 14, indicating Resident 3's cognition was intact. An observation and interview was conducted with Resident 3 on 8/21/24 at 11:21 A.M., as he sat on his bed. A small fan was clipped to the left upper bed rail. Resident 3 stated he was warm and uncomfortable. Resident 3 stated his family brought the small fan to him, since he was complaining about the temperature in his room. Resident 3 stated the facility never asked him if he wanted a fan, even though he complained to the staff about the heat. b. Resident 4 was admitted to the facility on [DATE], with diagnoses which included disorder of autonomic nervous system, (damage to the nerves that control body functions), per the facility ' s Admission Record. Resident 4 ' s MDS, dated [DATE], listed a cognitive score of 15, indicating Resident 4's cognition was intact. An observation and interview was conducted with Resident 4 on 8/21/24 at 11:23 A.M., as he walked around inside his room. A large stand-up fan was running and pointed directly towards his bed. Resident 4 stated he was very hot, so he had his family bring him a fan. Resident 4 stated he would like another fan if one was available. c. Resident 5 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-ineffective gas exchange in the lungs), per then facility ' s Admission Record. Resident 5 ' s MDS, dated [DATE], listed a cognitive score of 14, indicating Resident 5's cognition was intact. An observation and interview was conducted with Resident 5 on 8/21/24 at 11:24 A.M., as he laid in bed. Resident 5 was shirtless and wearing long pants. Resident 5 was non-verbal and shook his head in response to questions. Resident 5 nodded yes, when asked if he was hot. Resident 5 shook his head no, when asked if he was offered a fan. Resident 5 nodded yes, when asked if he would like a fan. d. Resident 6 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (a disease of the brain), per the facility ' s Admission Record. Resident 6 ' s MDS, dated [DATE], listed a cognitive score of 12, indicating Resident 6's cognition was intact. An interview was conducted with Resident 6 on 8/21/24 at 11:25 A.M., within his room. Resident 6 stated that he felt/was very hot, and he wanted a fan as soon as possible. e. Resident 7 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), per the facility ' s Admission Record. Resident 7 ' s MDS, dated [DATE], listed a cognitive score of 11, indicating Resident 7's cognition was intact. An interview was conducted with Resident 7 on 8/21/24 at 11:26 A.M., in his room. Resident 7 stated he felt/was hot and uncomfortable and would like a fan. Resident 7 stated that no one at the facility had asked him if he was hot or would like a fan. On 8/21/24 at 11:27 A.M., the wall thermostat in the west/south hallway, continued to indicate a temperature of 79 degree Fahrenheit (F). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 1:45 A.M., the MA conducted room temperature checks in the west hallway. The MA retrieved an infrared thermometer (a non-contact thermometer that measured temperature of an object by detecting thermal radiation it emits). Random rooms were selected, and the infrared thermometer was pointed on the wall farthest from the room entrance. (Federal regulation requires temperatures must be maintained between 71 F and 81 F.) Resident 7 ' s room was 82.5 F. Resident 5 and 6 ' s room temperature was 79.5 F Resident 3 ' s room temperature was 82 F. Additional rooms were checked on the west and east unit. Three rooms had temperatures at 81.5 F. One room was 81 F. Two rooms were 80.5. Four rooms were 80 F. A follow-up interview was conducted with the MA on 8/21/24 at 2 P.M. The MA stated the maintenance department did not routinely check resident room temperatures and they had no documentation or temperature log to prove that temperatures were checked and monitored. The MA stated they had not been checking room temperatures since the AC went out, and maybe they should have. The MA stated he had never been instructed to proactively check or document resident room temperatures. An observation of staff working areas was conducted on 8/21/24 at 2:15 P.M. Fans and portable air conditioning units were located and running in the admission ' s office, the west nursing station, the Director of Staff Services office and training room, the Director of Nursing office, and the social service office. The director of nursing (DON) was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M., the ADON stated that she and the DON were notified earlier by the MA about the temperature concerns. The ADON stated they had not ordered more fans or portable AC units at that time. The ADON stated they were waiting for the AC company to make repairs, but did not know when that would occur. The ADON stated she was unaware residents were complaining about the warm temperature and confirmed no staff had been asked to go room to room to inquire. The ADON stated she was unaware the maintenance department was not conducting routine temperature checks. The ADON was surprised to learn staffing department had fans and AC units, but none had been offered to the residents. The ADON stated she expected the residents to be comfortable. The ADON was unaware the California Department of Public Health (CDPH), had not been notified of the AC problem, stating yes, it was an unusual occurrence and CDPH should have been notified by the Administrator, before leaving on vacation . The temperature log for 8/21/24 from 4:15 P.M. through 4:23 P.M., was reviewed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Of the 35 rooms located on the west unit, nine room temperatures were above the 81 F. limit. One room was 90 F. One room was 84 F. One room was 83.5 F. Two rooms were 83 F. Two room were 82.5 F. One room was 82 F. One room was 81.5 F. An interview was conducted with the Director of Maintenance (DM) on 8/28/24 at 12:13. The DM stated he was aware there where AC issues when he started working at the facility, and he informed the Administrator. The DM stated he performed rounds (routine checks throughout the facility) when the AC company came to inspect the facility on 8/20/24. The DM stated that per the AC company, the AC units had not been serviced for a long time, the filters were dirty, and the AC blower fans needed to be replaced. The DM informed the Administrator and he was instructed to order three AC units. The DM stated that he routinely checked resident room temperatures but did not document the temperatures or maintain a temperature log because he was never told he had to. The DM stated the resident room temperatures should be maintained between 72 F. and 80 F. According to the facility ' s policy, titled Room Temperature, revised January 2012, .1. Resident care areas/resident rooms will be maintained at a minimum temperature of 71 degrees Fahrenheit to 81 degrees Fahrenheit per state regulation. 2. The Maintenance department is responsible for checking room temperatures and record in the maintenance logbook .4. All resident rooms will be checked monthly and logged in the maintenance temperature logbook. According to the facility ' s policy, titled Resident rooms and Environment, revised January 2012, The facility provides residents with a safe, clean, comfortable, and homelike environment .I. Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: . F. Comfortable temperatures .

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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 39220

Based on interview and record review, the facility failed to develop a person-centered care plan for one of two resident ' s (Resident 1) for repeated refusals of care and Activities of Daily Living (ADL- basic daily care such as bathing, dressing, brushing teeth, and combing hair).

This failure had the potential to result in miscommunication of necessary care, and inconsistent care that could result in delayed wound healing and infections for Resident 1.

Findings:

Resident 1 was admitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the inability to move arms or legs) with joint contractures (shortening of muscles, causing deformities of the joints), per the facility ' s Admission Record.

On 8/21/24, Resident 1 ' s clinical record was reviewed:

According to the Minimum Data Set, (MDS-a clinical assessment tool), dated 7/9/24, Resident 1 had a cognitive assessment score of 12, indicating cognition was intact. The Functional Abilities assessment indicated the resident was dependent on staff for turning, transferring from bed to chair, toileting, and showering. The skin assessment listed surgical wounds and moisture associate skin damage, (MASD-skin inflammation or erosion caused by prolonged exposure to bodily fluids), requiring the application of ointments and medications.

An observation and interview was conducted with Resident 1 on 8/21/24 at 11:29 A.M. Resident 1 had severe contractures of the left neck, causing her left head and left ear to rest directly on her left shoulder and contractures with redness and inflammation of the wrists and ankles. Resident 1 stated she needed staff assistance for showers and hygiene care, but she could feed herself. Resident 1 stated she had not refused any showers or bed baths.

On 8/21/24, the facility ' s west unit Shower Book dated July 2, 2024 through August 11th, 2024 was reviewed. According to the shower schedule, Resident 1 received showers every Monday and Thursday during the day shift. The shower book contained documentation that Resident 1 was offered a shower on 7/8/24, but refused. Another shower was offered on 7/15/24 and was refused three times. Resident 1 was offered a shower two out of seven opportunities for the month of July. Resident 1 received a bed bath on 8/1/24, with redness noted on the buttocks. A second bed bath was provided on 8/5/24.

According to the hospital Admission Record, Resident 1 was admitted to the hospital on 8/11/24 and was discharged back to the facility on [DATE], to a different nursing unit (east unit).

On 8/21/24, the east unit shower book dated August 17, 2024, through August 21, 2024 was reviewed. There was no documented evidence that Resident 1 was offered or received any showers or bed baths.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review of the east station ' s Shower Book was conducted with LN 1 on 1:15 P.M. LN 1 stated Resident 1 was offered a shower yesterday (8/20/24), by a certified nursing assistant (CNA), but refused. LN 1 could not locate documentation in the east station's Shower book for 8/20/24, that a shower was offered or refused. LN 1 stated CNAs needed to document the shower and if they were refused, it also needed to be documented. LN 1 stated since Resident 1 refused showers regularly, there should be a care plans for refusals and for the maximum staff assistance the resident required, but there were not any. An interview was conducted with Licensed Nurse 2 (LN 2) on 8/21/24 at 1:30 P.M. LN 2 stated showers needed to be offered to resident ' s at least twice a week. LN 2 stated that if a resident refused showers repeatedly, it needed to be documented and care planned, so the interdisciplinary team (IDT- department staff who meet to identify potential problems), could investigate why the resident was refusing showers. LN 2 stated that residents might refuse showers because of behavior problems, pain, confusion, or they do not like a particular staff member. LN 2 stated once the IDT identified the issue and why, the care plan needed to be updated, so all staff were aware of the issue and the resident ' s concerns. LN 2 stated showers were important for cleanliness, dignity, and to identify early skin issues. LN 2 stated Resident 1 was unable to care for herself and required staff assistance for all ADL care. On 8/21/24, Resident 1 ' s MAR dated August 2024 was reviewed for wound care: The physician orders for Ketoconazole (medication to treat fungal and yeast infections) External cream 2% (topical-applied onto the skin), dated 7/3/24, indicated to Apply to feet two times a day for skin infection. The MAR included documentation that Resident 1 refused this treatment 16 times out of 21 opportunities. The physician orders for Triad Hydrophillic (a paste that adheres to wet skin, keeping the wound protected from incontinence) dated 7/3/24, indicated to Apply to left hip and buttocks topically two times a day for dressing of wounds. Per the MAR, Resident 1 refused this treatment 16 times out of 21 opportunities. The physician orders of Trimciolone Acetonide (medication used to treat various skin conditions such as itching, redness, dryness, and crusting) External ointment 0.1% (topical) indicated to Apply to hands and knuckles topically two times a day for treatment of plaque area (a solid, raised, flat-topped lesion that's larger than 1 centimeter in diameter). Per the MAR, Resident 1 refused this treatment 18 times out of 21 opportunities. A care plan related to refusal of skin treatments was not developed. The Director of Nursing was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. The ADON stated resident showers were important and all staff needed to document when they were provided and if not, why. The ADON stated if residents were repeatedly refusing showers, it should be care planned and investigated on why the showers were being refused. The ADON stated Resident 1 should have a resident-specific care plan for ADLs, since she required maximum staff assistance and was unable to care or herself. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24, the Medical Records Director (MRD) indicated there were no IDT meetings for Resident 1 in July or August 2024, for refusal of showers or wound care. According to the facility ' s policy. titled Comprehensive Person-Centered Care Planning, revised August 2023, 4.b. Additional Changes or updates to the resident ' s comprehensive care plan will be made based on the assessed needs of the resident .c. The comprehensive care plan will be periodically reviewed and revised by the IDT after each assessment .iv. To address changes in behavior and care . According to the facility ' s policy, titled Refusal of Treatment, revised January 2012, .ll. When a resident refuses treatment, the Charge Nurse or Director of Nursing Services (DNS) interviews the resident to determine what and why the resident is refusing .III. The Charge or DNS will document information related to the refusal in the resident ' s medical record .IV. The Attending physician will be notified of refusal of treatment .V. The Interdisciplinary Team (IDT) will assess the resident ' s needs, and offer the resident an alternative treatments .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to provide routine showers and/or bed baths to one of two residents (Resident 1) reviewed for Activities of Daily Living (ADL-basic daily care such as bathing, dressing, brushing teeth, and combing hair). As a result, Resident 1 was at risk for skin infections and skin injuries. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the inability to move arms or legs) with joint contractures (shortening of muscles, causing deformities of the joints), per the facility ' s Admission Record. Resident 1 ' s clinical record was reviewed on 8/21/24: According to the Minimum Data Set, (MDS-a clinical assessment tool), dated 7/9/24, Resident 1 had a cognitive assessment score of 12, indicating cognition was intact. The Functional Abilities assessment indicated the resident was dependent on staff for turning, transferring from bed to chair, toileting, and showering. The skin assessment listed surgical wounds and moisture associate skin damage, (MASD-skin inflammation or erosion caused by prolonged exposure to bodily fluids), requiring the application of ointment and medication. A care plan, titled The resident is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs related to physical limitations, dated 7/15/24, developed by the Activities Director did not include interventions related to ADLs. There was no care plan related to ADLs or required staff assistance, due to Resident 1 ' s physical limitations. An observation and interview was conducted with Resident 1 on 8/21/24 at 11:29 A.M., while the resident was laying in bed. Resident 1 had severe contractures of the left neck, causing her left head and left ear to rest directly on her left shoulder and contractures of the wrists and ankles. Resident 1 stated she needed staff assistance for showers and hygiene care. Resident 1 stated she had not refused any showers or bed baths. On 8/21/24, the facility ' s west unit Shower Book dated 7/2/24 through 8/11/24, was reviewed. According to the shower schedule, Resident 1 was to receive showers every Monday and Thursday during the day shift. According to the shower record, Resident 1 was only offered a shower two out of seven opportunities for the month of July. Per Resident 1 ' s clinical record, Resident 1 was admitted to the hospital from 8/11/24 through 8/17/24 and returned to the east unit. On 8/21/24, the east unit shower book dated 8/17/24 through 8/21/24 was reviewed. There was no documented evidence that Resident 1 was offered or received any showers or bed baths during the indicated time frame. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LN 2 on 8/21/24 at 1:30 P.M. LN 2 stated showers needed to be offered to resident ' s at least twice a week. LN 2 stated if a resident refused showers repeatedly, it needed to be documented and care planned, so the interdisciplinary team (IDT- department lead staff who meet to identify potential problems), could investigate why the resident was refusing showers. LN 2 stated residents might refuse because of behavior problems, pain, confusion, or they do not like a particular staff. LN 2 stated once the IDT identified the issue and why, the care plan needed to be updated, so all staff were aware of the issue and the resident ' s concerns. LN 2 stated showers were important for cleanliness, dignity, and to identify early skin issues. An interview was conducted with the Director of Staff Development (DSD) on 8/21/24 at 2:09 P.M. The DSD stated a certified nursing assistant (CNA) recently told him residents were complaining because showers were not being offered or were given late, and not on their scheduled days. The DSD provided a copy of an in-service he provided to the evening shift (3 P.M.-11:30 P.M.) staff on 8/8/24 and 8/9/24, titled Showers and Care. The in-service had signatures of 11 CNAs attending. There was no documented evidence that in-services were provided to the day shift (7 A.M.-3:30 P.M.) staff. The DSD stated showers were important for resident ' s hygiene and should be provided at least twice a week. The DSD stated if showers were not provided, residents were at risk of skin injuries and infections, that could go undetected. The director of nursing was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. The ADON stated resident showers were important and all staff needed to document when they were provided and if not, why the showers were not provided. The ADON stated if residents were repeatedly refusing showers, it should be care planed and investigated why the showers were being refused. The ADON stated she expected showers to be offered to resident ' s at least twice a week. According to the facility ' s policy, titled Showering and Bathing, revised January 2012, A tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors . XVII. Report any broken skin, bruises, rashes, cut, skin discoloration or reddened areas to the Charge Nurse. XVIII. Update th resident ' s Care Plan as needed. According to the facility ' s policy, titled Refusal of Treatment, revised January 2012, .ll. When a resident refuses treatment, the Charge Nurse or Director of Nursing Services (DNS) interviews the resident to determine what and why the resident is refusing .III. The Charge Nurse or DNS will document information related to the refusal in the resident ' s medical record . IV. The Attending physician will be notified of refusal of treatment .V. The Interdisciplinary Team (IDT) will assess the resident ' s needs, and offer the resident an alternative treatment .

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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 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** 39220 Based on interview and record review, the facility failed to provide wound treatments as ordered for one of seven residents (Resident 1). As a result, Resident 1 had the potential for delayed healing and worsening of wounds. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the inability to move arms or legs) with joint contractures (shortening of muscles, causing deformities of the joints), per the facility ' s Admission Record. On 8/21/24, Resident 1 ' s clinical record was reviewed: According to the Minimum Data Set, (MDS-a clinical assessment tool), dated 7/9/24, Resident 1 had a cognitive assessment score of 12, indicating cognition was intact. The Functional Abilities assessment indicated the resident was dependent on staff for turning, transferring from bed to chair, toileting, and showering. The skin assessment listed surgical wounds and moisture associate skin damage, (MASD-skin inflammation or erosion caused by prolonged exposure to bodily fluids), requiring the application of ointments and medications. According to the care plan, dated 7/3/24, titled Risk of Impaired Skin Integrity related to: .moisture wound left neck . Cleanse moisture wound left neck .every day for 30 days . According to the physician orders, dated 7/11/24, cleanse left neck wound with cleanser or normal saline, pat dry, apply medical honey (a medical-grade honey dressing used to treat wounds), followed by an abdominal pad every day for 30 days. According to the facility ' s Treatment Administrative Record (TAR) dated August 2024, wound treatments were not provided to Resident 1 ' s left neck wound on 8/10/24 and 8/11/24. According to the nursing progress notes dated 8/11/24 at 2:55 P.M., licensed nurse 4 (LN 4), documented, patient was found with maggots on her left ear. Visible maggots were removed. M.D.(medical doctor) was notified. Patient sent to (name of hospital) emergency room for evaluation. According to the emergency room medical records, Resident 1 had a notable wound on the left side of her neck and chest wall, between her left upper extremity and chest wall. The physician documented that there was notable discharge from the left external auditory canal (external left ear) with visible maggots in the left ear canal. The maggots were removed with suction. LN 4 was unavailable for an interview after several attempts were made. Resident 1 ' s certified nursing assistant (CNA 1) on 8/11/24, was unavailable for an interview after several attempts were made. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview was conducted with Resident 1 on 8/21/24 at 11:29 A.M. Resident 1 had severe contractures (shortening of muscles, causing deformities of the joints), of the left neck, causing her left head and left ear to rest directly on her left shoulder, and contractures of the wrists and ankles. Resident 1 stated she went to the hospital because bugs were found in her left ear and on her left neck. Resident 1 stated she did not refuse any wound treatments for her neck, but was particular on how the treatments were done, because it hurt when staff tried to lift her head from her left shoulder. An interview and record review of Resident 1 ' s TAR was conducted with the wound treatment nurse (Tx LN) 2 on 8/21/24 at 1:25 P.M. The Tx LN 2 stated Resident 1 was admitted with a lesion on her left neck, which was treated daily. Tx LN 2 stated Resident 1 preferred to lift her own head for the treatment, and did not like it when staff lifted her head, because it hurt. The Tx LN 2 stated it was difficult to clean Resident 1 ' s neck area and apply the medication of Medi-honey to the tight contracture, but staff did their best. Tx LN 2 stated he did not provide the wound treatment to Resident 1 on 8/9/24, and he did not know whose initials listed were on the Treatment Record. The Tx LN 2 stated the TAR showed wound treatments were not performed on 8/10/24 and 8/11/24, which was the weekend, but the wound treatments should have still been provided. The Tx LN2 further stated that the wound treatments were ordered to be completed every day, because the wound had not yet healed. The Tx LN 2 stated if wound treatments were not performed as ordered by the physician, the wounds could worsen and become infected, which would affect the health of the resident. The Tx LN 2 stated there was no documented evidence that Resident 1 refused wound care or why the wound treatment was not completed on 8/10/24 and 8/11/24. An interview was conducted with LN 5 on 8/21/24 at 1:35 P.M., after LN 5 ' s initials were identified on the TAR for performing the wound treatment on 8/9/24. LN 5 stated she was a registered nurse and was trained on providing wound treatments when she was hired to work at the facility. LN 5 stated she provided Resident 1 ' s wound treatment for the left neck on 8/9/24, since all the treatment nurses were busy. LN 5 stated Resident 1 did not want anyone to lift her head for her and would yell out stop if anyone tried. LN 5 stated that on 8/9/24, she cleaned Resident 1 ' s left neck wound, applied medication, and applied a large pad (used as a dressing) to cover the area. LN 5 stated she did not notice anything unusual with the wound during the dressing change. LN 5 stated she had performed wound care for Resident 1 approximately four other times. LN 5 stated daily wound care was important for monitoring the wound and preventing infection or worsening of the wound. LN 5 stated if wound care was not performed, the LN should document why it was not done and the physician needed to be notified. An observation was conducted in the west/north hallway of the facility on 8/21/24 at 1:37 P.M. Two doors leading to the outside patio/resident smoking area, were propped open and flies were observed within the west/east hallway, near the patio doors. The facility ' s administrator and director of nursing were unavailable for interviews. An interview and record review was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. regarding Resident 1 ' s wound treatments. The ADON stated she expected all wound treatments to be performed as ordered by the physician. (continued on next page)

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	055322	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON stated if wound treatments were not completed, the resident could be at risk of harm and worsening wounds. The ADON reviewed Resident 1 ' s TAR, and acknowledged treatments were not provided on 8/10/24 and 8/11/24. The ADON reviewed the nursing progress notes, and stated there was no documentation that indicated why the neck wound treatments were not performed. The ADON reviewed Resident 1 ' s medication administration record (MAR) dated August 2024, and stated that some ointment treatments on the MAR were refused, but that there was no documentation on the TAR that indicated treatment for Resident 1 ' s neck was provided or refused. According to the facility ' s policy, titled Skin and Wound Management, revised January 2012, The facility Staff will take appropriate measures to prevent and reduce the likelihood that residents will develop pressure ulcers and other skin conditions .II. Skin and Wound Management: .C. Treatment for skin problems, wounds and non-pressure ulcers will be assessed and documented by the Licensed Nurse .III. Documentation: A.i. Licensed nurses will document effectiveness of current treatment for wounds and non-pressure ulcers, wound in the resident ' s medical chart .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39220 Based on observation, interview, and record review, the facility failed to a maintain a hazard free environment when: 1. Liquids (shampoo, body wash, and shaving cream containers) were unsecured in two of three resident showers (west/east hallway and west/south hallway) 2. A red sharps container (a one-way device that contains needles and other sharp devices) was unsecured, and over-flowing with blue used razors, in one of three showers rooms (west/east hall) 3. Water was leaking from an adjacent wall in the west/east hallway, next to the east nursing station. These failures had the potential for confused residents to ingest shampoo, body wash, lotions, shaving cream and to have access to used razors, along with potential for slipping on the wet floor. Findings: On 8/12/24, an unannounced visit was conducted. 1. An observation of the shower room located in the west/east hallway was conducted on 8/12/24 at 10:31 A. M. The shower room was unlocked and appeared recently used, due to the presence of wet towels on the ground. On a metal shelf to the right of the interior door, just outside the shower area, were multiple small containers of unidentified liquid substances. An observation was made of the west/south hallway shower room on 8/21/24 at 10:35 A.M. Multiple small containers of unidentified liquid substances were on a metal shelf to the right, and inside the shower area, resting on metal handrails. The shower room was unlocked, and easily accessed. A second observation was conducted of the west/east hallway shower room on 8/21/24 at 11:08 A.M. The wet towels were removed, however liquid chemicals were still on the interior metal shelf. An observation of the west/south hallway shower and interview was conducted with the Director of Staff Development (DSD) on 8/21/24 at 11:19 A.M. The DSD observed the liquid containers that were left unattended in the shower room. Thirteen canister/containers were counted on the metal shelf to the right, and three containers were resting on the handrails, within the shower stall. Five of the containers had no lids on them and were open to the environment. The DSD stated that anyone could have access to these chemicals, since the doors did not lock. The DSD stated the facility had a few residents who were confused and cognitively impaired, and the possibility of ingestion could happen, because they (referring to the residents), did not know any better. The DSD stated staff were responsible for cleaning the showers after each use and disposing of the cleaning containers, so the shower was ready for the next resident. The Director of Nursing was not available for interview. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M The ADON stated there were some confused residents within the facility. The ADON stated since the shower doors were not locked, any resident could access the shower areas. The ADON stated if body wash and shampoo were left in the shower area, there was a potential for confused residents to ingest them, which could cause harm. 2. An observation of the west/east hallway shower room was conducted on 8/12/24 at 10:31 A.M. The shower room was unlocked and appeared recently used, due to the presence of wet towels on the ground. A red sharps container (a container designed to receive sharp objects such as razors, needles etc.) was attached to the right wall, next to the metal shelf. The red sharps container was full and contained multiple blue used razors resting on top of the drop (opening) slot. A second observation was conducted of the west/east hallway shower room on 8/21/24 at 11:08 A.M. The red sharps container was still overflowing, and now a pair of brown socks was resting on top of the red sharps container, along with the used razors. An interview was conducted with the supervisor of housekeeping (S-Hskp) on 8/21/24 at 11:13 A.M. The S-Hskp stated his department was not in charge of biohazards (red sharps container). The S-Hskp stated that the central supply (department) was responsible for removing and replacing the sharps containers. An interview was conducted with the central supply (CS) staff on 8/21/24 at 11:14 A.M. The CS stated nursing (staff) were responsible for removing and replacing the sharp containers. An observation of the west/east shower room and interview was conducted with the charge nurse, Licensed Nurse 1 (LN) on 8/21/24, at 11:15 A.M. LN 1 stated all LNs had keys to remove and replace the red sharps containers. LN 1 viewed the sharps container on the right wall within the west/east shower room. LN 1 stated, That is unacceptable and a hazard. LN 1 stated anyone could have access to the sharp razors, which could cause injury. The Director of Nursing was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. The ADON stated it was unacceptable to leave used razors on top of the sharps containers, because residents could cut themselves, or become injured. 3. An observation of the floor, across from the east nursing station in the north/south hall was conducted on 8/21/24 at 10:46 A.M. Multiple bath blankets and towels were on the floor, against the north wall and were saturated with water, which was leaking out on the floor. There were no, Caution Wet Floor signs or no caution tape, to warn others of the wet floor hazard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview was conducted on 8/21/24 at 10:48 with the maintenance aide (MA). The MA stated that on the other side of the wall was a water leak from a water dispenser. The MA stated it had been leaking for one week and they called a water dispenser company to fix it. The MA stated the water dispensing company did not have the part required to fix it, so they, rigged up a temporary solution, until the part came in. The MA stated the water dispenser started leaking again shortly after the water dispenser company left, and he has been calling the company every day since, to come back, but that no one has answered the phone. The MA stated they had not tried calling other water dispensing companies to have it fixed. The MA stated he will try to call the company again. A second observation was conducted of the floor in the east unit, next to the north hall on 8/21/24 at 1:13 P. M with the MA. The bath blankets and towels on the floor were wet, and spongy. The MA stated he was able to reach the water dispenser company, and they would come back out, but the water company could not provide a date or time of expected arrival. The Director of Nursing was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. The ADON stated the water leak on the main west/east hallway, should have been fixed immediately to avoid slippage and falls. According to the facility ' s policy, titled Resident Safety, dated April 2021, VII. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. VIII. The Safety Committee will review the occurrence of accidents in the Facility at least quarterly to identify patterns or trends . According to the facility ' s policy, titled Sharps Disposal, dated January 2012, .III.C. The Infection Control Coordinator or designee is responsible for sealing and replacing containers when they are 75% TO 80% FULL TO PROTECT Nursing Staff from punctures and/or needle sticks when attempting to push sharps into the container .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39220 Based on observation and interview, the facility failed to secure one of two medication carts (cart north), one of two treatment carts (cart north), and one of one intravenous (IV) cart all stored on the east unit, reviewed for safe medication storage. As a result, residents, visitors, and staff had access to unauthorized medications and IV needles. Findings: On 8/21/24, an unannounced visit was made to the facility. An observation was conducted of a medication cart on 8/21/24 at 10:52 A.M., on the east station, north hallway. The medication cart was backed against a wall, in a hallway between two resident rooms and was unlocked. The first and second right drawers contained multiple medications, the top left drawer contained insulin (a hormone used for people with diabetes) pens (injection device preloaded with insulin). On 8/21/24 at 10:53 A.M., licensed nurse (LN) 2, exited a resident room and approached the medication cart. LN 2 acknowledged that she left the cart unlocked and proceeded to lock it. LN 2 stated when the (medication) cart was left unlocked, anyone could have access and removed medications, which might cause harm. An observation was conducted of a treatment cart on 8/21/24 at 10:53 A.M., across the hall, north from the previously unlocked medication cart. The treatment cart was backed against a wall and was left unlocked and unattended. In the top drawer were medicated creams and ointments. Further down the hall was another treatment cart with two treatment nurses standing (Tx LNs) next to it. Tx LN 1 stated she did not know who the treatment cart (backed against the wall) belonged to, because (Tx LN 1) had her own treatment cart. TX LN 1 stated treatment carts should always be locked when not in use, because anyone would have access to the cart ' s contents. An observation was conducted of an unlocked intravenous (IV-equipment that provides medications and fluids to the veins) cart on 8/21/24 at 10:55 A.M. on the east unit in the south hallway. The IV cart contained packaged needles in the top drawer. Inside the third and fourth drawer were liquid bags of medications with labels, containing resident names. An observation of the IV cart and interview was conducted with the charge nurse (LN 3) on 8/21/24 at 10:56 A.M. LN 3 stated the IV cart should always be locked when not in use. LN 3 stated anyone could have access to the needles and medications kept within the cart, which could be harmful. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with LN 1 on 8/21/24 at 1:30 P.M. LN 1 stated medication, treatment, and IV carts all needed to be locked to maintain safety. LN 1 stated if the carts were not locked, anyone could have access to the contents, which could include medications, scissors, and needles, all of which could be harmful. LN 1 stated it was the responsibility of the nurses to lock the cart and to protect the contents. The Director of Nursing was not available for an interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/24 at 2:22 P.M. The ADON stated medication, treatment, and IV carts all contained potential hazards if accessed or used in the wrong way. The ADON stated she expected all nurses to lock their carts when not being used. The ADON was unable to provide a policy for safe medication storage, stating the facility used the Centers for Medicare and Medicaid Services (CMS) critical element pathway titled, Medication Storage and Labeling, dated 2/2017 (Form CMS-20089), as their policy.