STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055328	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Care Center	5602 University Ave San Diego, CA 92105

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on interview and record review the facility failed to ensure that a Certified Nursing Assistant (CNA) and a Licensed Nurse (LN) provided by an agency (a company that supplies staff) had the necessary competency to document care during their shift. As a result, CNA 1 did not document any care provided for Resident 1, sampled for death, and LN 1 documented medications were given late. Additionally, no change of condition documentation and physician notification were done regarding abnormal laboratory results, and no follow-up social services notes were documented for Resident 1's roommate who was in the room when he died . The facility was not able to provide requested evidence of the events prior to Resident 1's death in the facility. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs), diabetes mellitus type two (a chronic disease that occurs when the body cannot control the amount of sugar in the blood) with chronic kidney disease stage three (a condition in which the kidneys are mildly to moderately damaged), acute respiratory failure with hypoxia (a chronic condition of the lungs in which oxygen is low in the blood) and pulmonary hypertension (a serious condition in which the blood pressure in the lungs is higher than normal). CNA 1 and LN 1 were not working at the facility during the investigation and did not respond to the facility request for a telephone interview. On [DATE] at 1:35 P.M. a telephone interview was conducted while at the facility with the Director of Nursing (DON) who was not onsite. The DON stated, I see that the day shift CNA did not document through her shift. I expect them obviously to be able to chart accurately meaning everything that happens to a patient during their shift should be documented, that includes ADLs (Activities of Daily Living, the basic tasks people need to do to care for themselves), toileting, and the amount eaten during meals. The DON stated the CNA and Licensed Nurse assigned to Resident 1 were agency staff and did not participate in staff trainings at the facility. The DON stated, I do not see any notes about social services following up with the roommate to see how he was doing after the death. The follow up should have been documented. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:32 P.M. a telephone interview and concurrent record review were conducted with the DON who stated the agency provided training to their staff but their skills checklists did not include documenting care provided. The DON further stated that no employee at the facility reviewed the agency portal to ensure temporary staff had skills checklists prior to allowing them to come work at the facility. A concurrent review of Resident 1's laboratory results with multiple abnormal findings were reviewed. The DON stated Resident 1 had abnormal laboratory results. The DON stated no change of condition notes were written about abnormal lab results and If there's abnormal labs it should be reported to the doctor. There is no note that says the physician was notified. A concurrent record review of Resident 1's orders indicated Basaglar KwikPen subcutaneous solution Pen-injector (a long acting insulin used to control high blood sugar) 100 u/ mL (milliliter) was due to be administered at 9 P.M. nightly. The DON stated the insulin administration was documented late on ,d+[DATE] at 11:31 P.M., one- and one-half hours past the maximum time to administer the medication. A concurrent record review of Resident 1's medication administration record (MAR) indicated Lispro (a fast-acting insulin used to control high blood sugar) if (blood glucose result of) ,d+[DATE] give 0 units; ,d+[DATE] give 2 units, ,d+[DATE] give 3 units, ,d+[DATE] give 4 units, ,d+[DATE] give 5 units, , d+[DATE] give 6 units, 401+ administer 7 units and notify MD (Medical Doctor). A concurrent record review of the MAR indicated on [DATE] a dose of Lispro was due at 12 noon and was administered at 2:26 P.M., one- and one-half hours past the maximum time to administer the medication. A dose of Lispro was due on [DATE] at 7 A.M. and was administered at 12:07 P.M., four hours past the maximum time to administer the mediation. A dose of Lispro was due on [DATE] at noon and was administered at 1 P.M. The DON stated he did not have any documentation to clarify if two doses of Lispro were given within one hour of each other on [DATE]. A dose of Lispro was due on [DATE] a dose of Lispro at 7 A.M. and was documented as administered at 8:29 A.M., one-half hour past the maximum time to administer the medication. The DON stated, It is late. There's no excuse. Nurses should document medication as it's given. Nurses are aware that they should prep, administer then sign. A concurrent review of laboratory results drawn at 5:30 A.M. on [DATE] indicated Resident 1 had a low blood glucose level of 64. According to the laboratory report, a normal range was ,d+[DATE]. A review of the facility policy titled Administering Medications dated 2011 indicated, Medications will be administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame.Medication errors are documented, reported and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. Medications are administered within one (1) hour of their prescribed time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on observation, interview and record review, the facility failed to prevent an accumulation of old food and beverage items at the bedside of one resident, Resident 2, sampled for infection prevention. The facility also failed to provide regular showers or bed baths and clean clothing to Resident 2 who had open sores on his arms and face. As a result, Resident 2 was at risk for foodborne illness and infection of his open wounds. Findings: Resident 2 was admitted to the facility on [DATE] with diagnoses that included depression (a mental health condition that involves a persistent feeling of sadness), severe protein-calorie malnutrition (a condition that occurs when the body doesn't get enough protein, calories and other nutrients), mood disorder (a mental health condition that involves persistent changes in a person's emotional state), malignant neoplasm of bronchus and lung (a type of tumor in the lower airways and lung), and homelessness. On 11 /13/24 an unannounced visit was made to the facility. On 11/13/24 at 2:50 P.M., an observation and interview were conducted with Resident 2 who was lying on his bed. Resident 2 was noted to have many dried scabs and open sores on the exposed parts of his arms and on his face. Reddish-brown smudges were noted on many areas of the fitted sheet on Resident 2's bed. Many food and beverage items were noted on Resident 2's overbed table and dresser. Many small flying insects were noted in Resident 2's shared room, landing on the resident's skin and on his food and beverages. Many insects were also on the privacy curtain between the two beds in the room. Resident 2 waved his arms to move the insects away and off his skin. Additionally, Resident 2 was noted as wearing soiled black sweatpants and a soiled burgundy shirt, with disheveled hair. The furniture surfaces and floor surrounding Resident 2 were notably dirty. Resident 2 stated They are cleaning the area sometimes and bathing sometimes. On 11/13/24 at 3:15 P.M., an observation and interview were conducted with Certified Nursing Assistant (CNA) 2 who stated, Old food could make him sick. He might not like all those flies landing on him. CNA 2 was not able to answer what the risk of insects landing on Resident 2's wounds and food was. On 11/13/24 at 3:25 P.M., an observation and interview were conducted with the Infection Preventionist (IP) who stated, It's not ok to have flies, they can lay eggs and get into the food. I'm not sure why the food is still there. The food shouldn't be in there for more than a couple of hours, they should throw it out and get new ones. A joint observation of a urinal on an overbed table in the room across the hall was made. A sign for Enhanced Barrier Precautions (EBP) was noted on the wall outside of the room. The IP stated the resident was on EBP precautions for a wound. The IP stated, Having a urinal on the table is an infection control risk, it should not be there. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 3:45 P.M., a joint observation of Resident 2's living situation was conducted with the Administrator (ADM). The ADM stated, If they're exposed to infestation it's a risk to their skin. Old food is a risk for foodborne illnesses. On 11/14/24 at 3 P.M., a telephone interview was conducted with the Director of Nursing (DON) who stated, I don't know how long it's ok to keep the food in the room. The risk is he might get sick. On 11/14/24 at 3:35 P.M., a telephone interview was conducted with the Certified Dietary Manager (CDM) who stated, I'm not 100% sure how long perishable foods can be left at the bedside at room temperature or in the kitchen, I'd have to check the policy. On 11/15/24 at 1:05 P.M., a telephone interview was conducted with the CDM who stated, Time temperature-controlled food can be kept at the residents bedside for two hours. The concern is risk for foodborne illness. On 11/15/24 at 1:29 P.M., a telephone interview was conducted with the Registered Dietician (RD) who stated, food can be held at room temp for two hours. The policy says that they are to remove the food after two hours. The risks are nausea, vomiting, diarrhea, bloating, dehydration. Food insecurity was in my evaluation. At admission his background was identified, he had homelessness in his diagnosis. On 11/20/24 at 3:24 P.M., a telephone interview and concurrent record review of Resident 2's shower log were conducted with the DON. Between 10/29/24 and the time of the onsite investigation, Resident 2 received one shower and had his toenails trimmed on 11/5/24. The DON stated residents are supposed to be showered or bathed twice per week and nail care is no less than once a week. The DON stated Resident 2 did not receive this care. The DON stated, It's important for him to be kept clean because it's going to create a medium for bacteria to grow and he might get infected. Nail care is no less than once a week. A review of the facility pest control contractor's report dated 10/28/24 indicated, monthly service . Spot treated employee break room for fruit fly activity. A review of the facility policy titled Infection Prevention and Control Program dated 2001 indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the facility policy titled Bath, shower/ tub dated 2001 indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.