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	05/07/2025

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services to meet professional standards for two of 18 sampled residents when: 1.Resident 129's PICC line (peripherally inserted central catheter- a thin tube placed in the vein of the upper arm and threaded towards the heart to deliver medications directly to the blood stream) 2. a gastrostomy tube (GT-tube inserted through the belly to bring nutrition and medications directly to the stomach) placement was not checked before medication administration for one resident (1). This failure had the potential for complications related to intravenous (IV - method of delivering medications directly into the bloodstream through a vein) therapy and causing complications related to GT health. Findings: 1. A review of the facility's admission record, Resident 129 was admitted to the facility on [DATE] with diagnoses to include bacteremia (presence of bacteria in the blood), diabetes type 2, endocarditis (a serious infection of the heart's inner lining), autistic disorder and cognitive communication deficit (difficulty understanding, paying attention to conversation and remembering information). A review of Resident 129's physician orders indicated the following: on 4/7/25 .PICC line dressing change as needed [measure external catheter length] . on 4/13/25 .PICC line dressing change every day shift every Sat[sic] {and measure external catheter length} . on 5/4/25 IV PICC - Measure catheter length with each dressing change . On 5/5/25 at 8:35 A.M., observation and interview were conducted with Resident 129. Resident 129 had a PICC line on his right upper arm. Resident 129 stated he could not recall if the nurse measured his arm or the PICC line. (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 9:30 A.M., a concurrent interview and record review were conducted with licensed nurse (LN) 11. A review of the PICC line dressing change for April 2025 in the Medication Administration Record (MAR) for Resident 129, measurements for catheter length were not done. LN 11 stated PICC line measurement should have been done weekly as ordered by the physician and as needed with each dressing change. LN 11 stated the importance of measuring the catheter length was to ensure proper placement and prevent complications. On 5/6/25 at 10:39 A.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated there was no documentation to provide that Resident 129's PICC line length was measured on April 2025. On 5/7/25 at 12:15 P.M., an interview was conducted with the DON. The DON stated measuring the PICC line catheter length during dressing change was a standard of practice and should have been done. The DON stated the expectation was for registered nurses (RNs) should measure Resident 129's PICC line length weekly and should have been documented in the MAR. According to the facility's policy titled , Central Venous Catheter and Dressing Changes dated March 2022, indicated .6. measure the external length of the external central vascular device with each dressing change . Compare with the length documented at insertion . 2. Per the facility face sheet, Resident 1 was admitted to the facility on [DATE] with diagnoses that included attention to gastrostomy (presence of an artificial opening into the stomach) and dysphagia (difficulty swallowing). On 5/6/25 at 8:22 A.M., licensed nurse (LN) 21 was observed and interviewed during a medication administration for Resident 1. On 5/6/25 at 8:31 A.M., LN 21 entered Resident 1's room. LN 21 explained the procedure to Resident 1 and detached Resident 1's GT from the nutrition feeding tube. LN 21 attached a syringe to the GT and flushed the GT with water. LN 21 then proceeded to administer medications. On 5/6/25 at 8:45 A.M., LN 21 stated she was done with administering Resident 1's medications. LN 21 acknowledged she did not check placement prior to administering medications to Resident 1. On 5/7/25 at 2 P.M., an interview with the Director of Nursing (DON) was conducted. The DON agreed that all nurses need to check GT placement prior to administering medications and that it is important to help prevent complications. A review of the facility policy titled, Administering Medications through an Enteral Tube dated November 2018, .6. Verify placement of feeding tube .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently provide pressure ulcer preventative measures to one resident (178) when, Resident 178 was not turned every two hours. This failure had the potential for Resident 178 to develop pressure ulcers or skin breakdowns. Findings: A review of Resident 178's admission Record indicated that Resident 178 was admitted to the facility on [DATE] with diagnoses that included Acute Respiratory Failure with Hypoxia (a condition wherein the lungs cannot adequately transfer oxygen to the blood) and Dysphagia(difficulty swallowing food and liquids). During the initial tour on 5/4/25 at 9:15 A.M., was conducted with Resident 178. Resident 178 was observed lying on his back with his head of bed elevated. Resident 178 had his oxygen on at 2 liters per minute and his tube feedings being infused. During an observation on 5/5/25 at 8:20 A.M., Resident 178 was lying in bed on his back with the head of his bed elevated. During an observation on 5/4/25 at 9:50 A.M., Resident 178 was lying in bed on his back with pillows under his left arm. A concurrent observation and interview on 5/5/25 at 10:40 A.M., with family member (FM) 1 was conducted. Resident 178 was still lying in bed on his back with his tube feedings being infused. FM1 stated I haven't seen anyone turned and repositioned him since I got here this morning. During an observation of Resident 178 on 5/5/25 at 12 noon, Resident 178 was lying in bed on his back with his left arm on a pillow. During an observation of Resident 178 on 5/5/25 at 12:40 P.M., Resident 178 was lying on the bed on his back with his left arm on a pillow. During an observation of Resident 178 on 5/5/25 at 2:00 P.M., Resident 178 was lying on the bed on his back with his left arm on a pillow. During an observation of Resident 178 on 5/5/25 at 3:27 P.M., Resident 178 was lying on his back with a pillow underneath his left arm. During an observation of Resident 178 on 5/5/25 at 4:20 P.M., Resident 178 was still lying on his back with a pillow underneath his left arm. An interview on 5/6/25 at 9:20 A.M., with Licensed Nurse (LN) 1 was conducted . LN1 stated it was important to turn and reposition Resident 178 to prevent skin breakdowns and provide comfort . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint observation and interview on 5/6/25 at 1:27 P.M., with Treatment Nurse (TN) was conducted. The TN stated Resident 178 must be turned and repositioned every 2 hours to prevent skin breakdown. A joint observation and interview on 5/7/25 at 7:35 A.M., with certified nursing assistant (CNA) 3 was conducted. Resident 178 was positioned facing his right side with pillows underneath his back . CNA 3 stated she worked with Resident 178 most of the time in the morning shift. CNA 3 stated Resident 178 was dependent on his activities of daily living (ADLs). CNA 3 stated Resident 178 was incontinent of both bladder and bowel although Resident 178 had a foley catheter previously. CNA 1 stated it was important to turn and reposition Resident 178 every 2 hours because Resident 178's left arm was contracted and to prevent further skin breakdown. A record review of Resident 178's minimum data set (MDS-a federally mandated assessment tool) indicated Resident 178's Brief interview for mental status(BIMS) score was 03 which meant Resident 178's cognition (thought process) was severely impaired. A record review of Resident 178's MDS section GG (functional abilities section) indicated Resident 178 was dependent on his activities of daily living- eating, toileting and transfers. A review of Resident 178's care plan titled, 4. At risk for skin breakdown related to Braden Risk score , impaired mobility, severely contracted and weakness indicated one of the interventions in Resident 178's care plan was to turn and reposition every 2 hours to prevent skin breakdown/ bedbound. An interview on 5/7/25 at 2 P.M., with the Director of Nursing (DON) was conducted. The DON stated it was important to follow the doctor's order of turning and repositioning Resident 178 every 2 hours to prevent skin breakdown. A review of the facility's policy dated 4/2020 titled Prevention of Pressure Injuries ' indicated mobility / repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule . 2. Choose a frequency for repositioning based on the resident's risk factors .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation , interview and record review, the facility failed to ensure a tube feeding formula was labeled for one resident (178) reviewed for Parenteral Nutrition. This failure had the potential to affect Resident 178 health conditions and decline. Findings: A review of Resident 178's admission Record indicated that Resident 178 was admitted to the facility on with 4/15/2025 with diagnoses that include Dysphagia (difficulty swallowing food and liquids) and Aphasia (a language disorder that affects a person's ability to communicate). During the initial tour on 5/4/25 at 9:15 A.M., an observation was conducted. Resident 178 had a gastrostomy feeding tube (a tube inserted through the stomach) with formula of Fiber source HN at 65 ml per hour with water running at 20 ml per hour per the feeding pump machine. Resident 178's feeding tube formula was not labeled . An interview on 5/4/25 at 9:32 A.M., with Licensed Nurse (LN) 2 was conducted. LN 2 stated she worked per diem for the facility and was not aware of the tube feeding formula not labeled. LN 2 stated it was important to label the feeding tube formula to follow the routes of medication administration and for Resident 178's safety. An interview on 5/7/25 at 9:32 A.M., with the Director of Nursing (DON) was conducted. The DON stated it was important to label the formula for accuracy, safety and follow the routes of medication administration and the Physician's orders, thus preventing complications. A review of the facility's policy titled, Enteral Feedings- Safety Precautions indicated preventing errors in administration 1. Check the enteral nutrition label against the order before administration. Check the following information. a. Resident name, ID and room number b. type of formula c. date and time formula was prepared. 2. On the formula label document initials, date and time the formula was hung and initial that label.

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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. Based on observation , interview and record review, the facility failed to ensure clean and used utensils were separated during a preparation of pureed meals. This failure had the potential to affect the health and safety of all residents. An observation on 5/5/25 at 10:30 A.M., was conducted with the [NAME] (CK) and the registered dietician (RD). The CK was observed preparing a pureed meal for 9 residents in the facility. The CK placed 20 pieces of tortillas and 3 cups of turkey meat in a chicken broth and placed them in a blender. The CK used a large mixing spoon to mix the tortillas and the turkey meat in the blender. The CK stated she wanted to make sure that the mixture was smooth and was free of lumps after blending the ingredients together. Then the CK placed the large mixing spoon in a tray of clean mixing spoons and colored scoops together. An interview on 5/5/25 at 11 A.M., with the CK was conducted. The CK stated she was nervous, and it was her first survey to be watched . The CK stated it was important not to mixed used and clean utensils to prevent possible contamination thus affecting the residents' health in the facility. An interview on 5/5/25 at 11:10 A.M., with the Registered Dietician (RD) was conducted. The RD stated she saw what the CK placed the used large mixing spoon with the clean utensils. The RD stated it was not right to mix clean and used utensils together to prevent contamination. An interview on 5/7/25 at 10 A.M., with the Director of Nursing (DON) was conducted. The DON stated it was important not to mixed clean and used utensils to prevent cross contamination thus preventing resident's health decline and or condition. A review of the facility's policy dated, 2/2025 titled Food Preparation and Service indicated, food preparation area .#4 appropriate measures are used to prevent cross contamination.

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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 - Some	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** Based on interview and record review, the facility failed to maintain complete Physician Orders for Life Sustaining Treatment (POLST - a medical form to communicate a resident's end of life wishes) for three of 18 residents (4,128, 129) reviewed for complete and accurate medical records. This failure did not provide an accurate representation of the care provided and had the potential to cause confusion amongst care providers. Findings: 1. Resident 4 was re-admitted on [DATE] to the facility with diagnoses to include dementia (type of memory loss), muscle weakness and adult failure to thrive according to the Admisison Record. 2. Resident 128 was admitted on [DATE] to the facility with diagnoses to include hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness following a stroke) according to the Admisison Record. 3. Resident 129 was admitted to 4/6/25 to the facility with diagnoses to include bacteremia (presence of bacteria in the blood), diabetes type 2, endocarditis (a serious infection of the heart's inner lining), autistic disorder and cognitive communication deficit (difficulty understanding, paying attention to conversation and remembering information) according to the admission Record. On 5/6/25 at 11 A.M.,a concurrent interview and record review were conducted with licensed nurse (LN)11. LN 11 reviewed POLST forms for Residents 4,128 and129. LN 11 stated POLST forms for Residents 4,128 and129 were incomplete.The following were reviewed: Resident 4's POLST on 4/6/25 was incomplete. Resident 128's POLST was incomplete. Resident 129's POLST was incomplete. LN 11 stated Residents 4's, 128's and 129's should be completed. LN 11 stated POLST should indicate the date when the physician and patient or legally recognized decisionmaker to determine the date the POLST was effective. LN 11 stated relationship should be indicated to verify the person who signed and the relationship to the resident. On 5/7/25 at 12:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated POLST should be completed for validity purposes and make sure resident wishes were followed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure infection control practices were implemented when: 1. Clean linens were mixed with packages that were transported from outside facility 2. Trash cans were inside the clean linen closets 3. Dusty and debris on the floor of the clean linen closets 4. A licensed nurse (LN 21) did not wear an isolation gown while administering medications to a resident (1) with a gastrostomy tube (GT-feeding tube inserted through the belly to bring nutrition and medications directly to the stomach). These failures had the potential to spread infections. Findings: 1. On 5/7/25 at 8:28 A.M., a concurrent observation and interview were conducted with the Director of Environmental Services (DES) and Infection Preventionist Nurse (IP). The closet was observed with clean linens in contact with packages. The DES stated facility have outside company doing their laundry. The DES stated the outside company transported clean linens packaged in plastic bags. The IP stated there should not be packages of plastic bags in contact with clean linens. The DES stated the packaging should be removed before placing the clean linens in the closets. 2. On 5/7/25 at 8:36 A.M., a concurrent observation and interview were conducted with the Director of Environmental Services and Infection Preventionist Nurse (IP). The facility had three closets with clean linens. The clean linen closets were observed each with a trash can. One trash can was observed with used gloves inside. The DES states the trash can were inside each closet for staff to place packages of disposable briefs. The IP stated there should not be trash cans inside the clean linen closets. 3. On 5/7/25 at 8:48 A.M., a concurrent observation and interview were conducted with the Director of Environmental Services (DES) and Infection Preventionist Nurse (IP). The clean linen closets were observed to have dust and debris on the floor. The DES and the IP stated should be cleaned. On 5/7/25 at 12:30 P.M., an interview was conducted with Director of Nursing (DON). The DON stated the clean linen plastic packaging should be removed. The DON stated the plastic packaging of the transported clean linens served as the barrier to prevent contamination. The DON stated the clean linen closet should not have a trash can and should not have dust and debris on the floor because clean linen closet should be free from trash and dust. According to the facility policy titled Laundry and Bedding, Soiled, dated September 2022, indicated .Clean linen is protected from dust .Clean linen is stored separately . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to the facility face sheet, Resident 1 was admitted to the facility on [DATE] with diagnoses that included attention to gastrostomy (presence of an artificial opening into the stomach). Per Resident 1's physician's orders, on 4/1/2024, an order was made for Enhanced Barrier Precautions (EBP-an evidence-based practice that expands the use of gloves and gowns during high-contact resident care activities, especially for those at increased risk of acquiring or spreading multidrug-resistant organisms -MDROs) related to indwelling device: feeding tube. On 5/6/25 at 8:22 A.M., LN 21 was observed and interviewed during a medication administration for Resident 20. LN 21 had a face mask on, did hand hygiene with hand sanitizer, knocked on the door, introduced herself, identified Resident 1 with ID arm band and explained the procedure. On 5/6/25 at 8:31 A.M., LN 21 detached Resident 1's GT from the nutrition feeding tube. LN 20 attached a syringe to the GT and flushed the GT with water. LN 20 then proceeded to administer medications. On 5/6/25 at 8:45 A.M., LN 21 stated she was done with administering Resident 1's medication. LN 21 stated she did not know she needed to wear a gown when administering medications to residents with a GT who are on EBP. On 5/6/25 at 8:50 A.M., a concurrent interview and record review were conducted with LN 21 of the EBP signage posted outside of Resident 1's door. The EBP signage indicated that examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device care or use (.feeding tubes .). On 5/7/25 at 2P.M., an interview with the Director of Nursing (DON) was conducted. The DON agreed that all staff need to follow and adhere to all infection control procedures. A review of the facility policy titled, Enhanced Barrier Precautions, dated December 2024, indicated that examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . device care or use (.feeding tubes .).

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 sq ft. (square feet) per resident in nine of 39 resident rooms. This failure had the potential to affect resident quality of care and quality of life. Findings: Per review of the Client Accommodations Analysis form, the facility had nine resident rooms which did not meet the required square footage requirements of at least 80 square feet per resident. Room number - number of residents- sq feet 31--- 3 ----------209.00 33---- 3---------- 209.46 35-----3----------211.51 36-----3----------211.51 37-----3----------211.51 38-----3----------207.17 39-----3----------208.27 40-----3----------206.71 41-----3----------208.27 A confidential resident group interview was conducted on 5/5/2025 at 10:00 A.M. No residents expressed any concern with resident rooms. Observations from 5/4/2025 through 5/7/2025 were conducted of rooms 31, 33, 35, 36, 37, 38, 39, 40, and 41 , during the recertification survey. No quality of care or quality of life concerns were identified and observed that negatively impacted the residents residing in these rooms. Therefore, a continuance of the room variance is recommended.