STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055335	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Paloma Healthcare Center	3232 Thunder Drive Oceanside, CA 92056

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45645 Based on interview, record review, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for a resident who discharged to the hospital for 1 (Resident #84) of 3 residents reviewed for closed records. Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised ,d+[DATE], indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. An Admission Record indicated, the facility admitted Resident #84 on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of multiple sclerosis (an autoimmune disease that affects the central nervous system [brain and spinal cord]), urinary tract infection, and sepsis (a life-threatening medical emergency caused by the body's extreme response to an infection, often leading to organ dysfunction and potentially death). Resident #84's Progress notes dated [DATE] indicated a family member reported that Resident #84 seemed uncomfortable and requested a hospital transfer. The notes indicated the nurse found the resident gasping for air despite being on 5 liters of supplemental oxygen. The notes revealed the resident's family member insisted the resident be sent to the hospital. The notes revealed the nurse practitioner was notified and 911 was called. Resident #84's physician's order dated [DATE] revealed May send out Resident to ER [emergency room] for further Eval [evaluation]. Resident #84's Progress notes dated [DATE] indicated the resident was transferred to the hospital and left the faciity on [DATE] at 2:22 PM. A Hospital History and Physical Reports, dated [DATE], indicated, Resident #84 was admitted to the hospital on [DATE]. Resident #84's Progress notes dated [DATE] indicated, the resident had expired at the hospital on [DATE] at 4:55 AM. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A death in facility MDS assessment, with an Assessment Reference Date (ARD) of [DATE], indicated Resident #84 was coded as deceased at the facility. The MDS revealed the assessment was signed by MDS Nurse #1 on [DATE], confirming the accuracy of the information. On [DATE] at 10:49 AM, MDS Nurse #2 stated that she initially opened a discharge assessment with an ARD of [DATE], expecting MDS Nurse #1 to complete it. MDS Nurse #2 stated, however, MDS Nurse #1 later changed it to a death assessment with a new ARD of [DATE]. MDS Nurse #2 was unable to explain why the changes were made. On [DATE] at 6:09 PM, MDS Nurse #1 stated that after reading a progress note indicating the hospital had confirmed Resident #84's death, she assumed the resident had died the same day upon arrival and was not admitted . She stated that based on that assumption, she changed the MDS to a death assessment. According to MDS Nurse #1, this human error caused the MDS to be inaccurate, as it did not clearly reflect Resident #84's correct date and place of death. On [DATE] at 8:52 AM, MDS Nurse #2 stated that staff must ensure their coding and documentation were accurate and that assessments must reflect correct information, such as the date of death and whether the resident was sent to the hospital or passed away at the facility, to ensure the Centers for Medicare and Medicaid Services (CMS) received accurate data. According to MDS Nurse #2, Resident #84's MDS assessment was not accurate. On [DATE] at 9:31 AM, the Director of Nursing (DON) stated that all documentation and coding must be accurate, including the correct date, the resident's condition, and the discharge location, whether the resident was transferred to a hospital or passed away. On [DATE] at 8:55 AM, the Administrator stated the MDS team was expected to double, and triple check all information to avoid erroneous assessments, as MDS accuracy was essential.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37683 Based on interview, observation, record review, and facility policy review, the facility failed to follow physician orders for 1 (Resident #6) of 2 residents reviewed for skin conditions. Specifically, Resident #6 had an order, dated 03/26/2025, to schedule a dermatology appointment. However, no attempts were made to schedule a dermatology appointment until 04/15/2025. Findings included: A facility policy titled, Physician Orders, revised 06/2013, indicated, Physician orders must be given, managed and carried out in accordance with applicable laws and regulations. A facility policy titled, Resident Appointments, revised 03/2025, indicated, 1. [NAME] Clerk shall coordinate/schedule resident appointments. The policy also stated, 4. [NAME] Clerk will document the appointment in the resident's medical record. An Admission Record revealed the facility admitted Resident #6 on 06/11/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease without dyskinesia (involuntary muscle movements), hypertensive heart disease without heart failure, hyperlipidemia, obsessive-compulsive disorder, bipolar disorder, anxiety disorder, major depressive disorder, and schizoaffective disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/14/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 9, which indicated the resident had moderate cognitive impairment. Resident #6's Care Plan Report included a problem statement revised on 11/01/2024, that indicated, the resident had a body rash and was at risk for infection, skin breakdown, spreading of the rash, and worsening of the rash. Interventions directed staff to administer treatments as ordered and monitor for effectiveness; avoid use of harsh detergents, soaps, fragrances, or other irritating substances; encourage to avoid scratching; keep hands and body parts free from excessive moisture; laboratory or diagnostic tests as ordered to assist in determining etiology; moisturize dry and flaky skin to rehydrate skin; monitor and record any complaints of pain, itching, or discomfort. Resident #6's Order Summary Report, with active orders as of 04/16/2025, included an order dated 03/26/2025, that directed staff to schedule a dermatology appointment for rash that was not improving. Resident #6's Progress Notes, dated 04/15/2025 at 3:45 PM, indicated, the facility left a detailed voicemail for a dermatology office for Resident #6 to be seen regarding the ongoing rash on their body. The note was written by Central Supply, who was also the [NAME] Clerk. During an observation on 04/14/2025 at 10:56 AM, Resident #6 was noted to have red, inflamed splotches of skin all over their arms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2025 at 2:34 PM, Central Supply stated that when there was an order for a specialist, he would look at the resident's insurance and check which specialist was in network. He stated he would then reach out to that provider to ensure they were in network and from there, the provider would want a written referral with a doctor's order. Central Supply stated he would also send in pertinent medical information regarding the resident. He stated he might follow up five days later. Central Supply stated that every time he followed up, he documented who he spoke to and what office was contacted. He stated this would be in the progress notes under appointments. During the interview, the record was checked, but there were no notes related to Resident #6's dermatology appointment. Central Supply stated that, ideally, he tried to follow up within seven to 10 days. He stated he had seen Resident #6's order for the dermatology appointment, but he had not gotten to it yet as he had been focused on other orders. During an interview on 04/17/2025 at 10:33 AM, the Director of Nursing (DON) stated that nursing entered orders for residents to see a specialist. The DON stated the scheduler, who was also Central Supply, would then make an appointment. The DON stated that while it may take time to get an appointment scheduled, the specialist should be contacted sooner than two and a half weeks. The DON stated, furthermore, all attempts to contact the specialist should be documented. During an interview on 04/17/2025 at 11:08 AM, the Administrator stated that the [NAME] Clerk, who was also Central Supply, was responsible for making appointments for specialists. The Administrator stated the [NAME] Clerk should make attempts to contact the specialist right after receiving the referral, and he should leave messages right away. The Administrator stated the [NAME] Clerk should also document all contact attempts.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37683 Based on interview, record review, and facility policy review, the facility failed to follow the pharmacist's recommendations for 1 (Resident #6) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Medication Regimen Reviews, revised 05/2019, indicated, The Consultant Pharmacist reviews the medication regimen or each resident at least monthly. The policy revealed the section titled, Policy Interpretation and Implementation included 1. The Consultant Pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. Further review revealed, 8. Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physician for each resident identified as having a non-life threatening medication irregularity. The section further revealed, 12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. An Admission Record revealed the facility admitted Resident #6 on 06/11/2022. According to the Admission Record, the resident had a medical history that included diagnoses of obsessive-compulsive disorder, bipolar disorder, anxiety disorder, major depressive disorder, and schizoaffective disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/14/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident received an anticonvulsant medication during the assessment's lookback period. Resident #6's Care Plan Report included a problem statement revised 02/14/2025, that indicated the resident was at risk for social isolation, mood problems, and ineffective coping related to obsessive compulsive disorder, anxiety, depression, schizoaffective disorder, and bipolar disorder. Interventions directed staff to administer medications as ordered, assist the resident in identifying strengths and positive coping skills, behavioral health consults as needed, and observing for signs and symptoms of mania or hypomania, irritability, or mood changes. Resident #6's Order Summary Report, with active orders as of 04/16/2025, included an order dated 12/04/2024, for Depakote 250 milligrams (mg), with instructions to give two tablets by mouth two times a day for seizures; a total of 500 mg twice a day. A Consultant Pharmacist's Medication Regimen Review, dated 11/16/2024, revealed that the consultant pharmacist recommended a clarification of the indication for Resident #6's Depakote. The review revealed if the medication was to be given for seizure control, then therapeutic levels of the medication would be necessary. The review revealed if they were giving the medication for behaviors, the indication would need to be changed in the Medication Administration Records (MARs). The review revealed the only written response was no. The review revealed the provider did not provide a clinical rationale or further explanation of the response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Consultant Pharmacist's Medication Regimen Review, dated 01/25/2025, revealed that the consultant pharmacist recommended an adjustment of Resident # 6's valproic acid (Depakote) dosage, as the resident's levels were still sub-therapeutic for seizures. The review revealed the only written response was no. The review revealed the provider did not provide a clinical rationale or further explanation of the response. During an interview on 04/16/2025 at 8:48 AM, the Director of Nursing (DON) stated that a pharmacist came in monthly to make recommendations. The DON stated the recommendations went to her and the Case Manager. The DON stated the Case Manager was the one who followed up with the pharmacy recommendations. She stated that Resident #6's primary diagnosis for the Depakote was bipolar disorder. She stated that Nurse Practitioner (NP) #5 was the one who followed up with pharmacy recommendations. During an interview on 04/16/2025 at 9:12 AM, the Case Manager stated that the pharmacist came in and reviewed the residents' medications monthly. The Case Manager stated the pharmacist submitted his recommendations in a large packet. The Case Manager stated that once she received those packets, she separated the packets by provider and submitted them to the relevant physician or nurse practitioner. She stated if there was no new order, then there was no further documentation made beyond what the provider offered. During an interview on 04/162025 at 10:01 AM, Pharmacist #7 stated that the forms used for medication regimen review recommendations depended on the facility and their DON, and how they preferred to do those recommendations. Pharmacist #7 stated that because providers generally did a good job following his minor recommendations, he entered them on the nursing recommendation report. Pharmacist #7 stated more serious recommendations, or recommendations that were directed at psychiatry, may be on their own forms. Pharmacist #7 stated that when he saw Resident #6's low dosage of Depakote, he suspected that it was for psychiatric purposes and not seizures. He stated he made the recommendation (on 11/16/2024) to clarify the medical record. Pharmacist #7 stated when the physician documented that they would not follow the recommendation, he recommended an increase in the dosage to treat seizures. He stated that he had followed up in January (2025) about his recommendations. During an interview on 04/17/2025 at 10:33 AM, the DON stated that the physician should document their clinical rationale for not following a pharmacist's recommendation. She stated she did not know why NP #5 did not document her clinical rationale regarding the Depakote. She stated she did not know why the facility did not follow up with the recommendation. During an interview on 04/17/2025 at 11:38 AM, NP #5 stated she understood she should have documented the clinical rationale for not following a pharmacist's recommendation as opposed to only writing no. She stated that she documented that the Depakote was for mood and not seizures in her notes, but she confirmed that the pharmacist would not necessarily see that documentation, so it was more prudent to document on the medication regimen review forms for the pharmacist to see.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37683 Based on interview, record review, and facility policy review, the facility failed to offer the influenza vaccine and provide education regarding influenza immunizations for 1 (Resident #32) of 5 residents reviewed for immunizations. Findings included: A facility policy titled, Influenza Vaccine, revised 08/2016, indicated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives). The facility policy indicated, 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. The policy indicated, 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. An Admission Record revealed the facility admitted Resident #32 on 02/05/2025. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 4, which indicated the resident had severe cognitive impairment. Resident #32's Immunization History Report revealed the resident's last influenza vaccination was 02/11/2020. The report revealed there was no other documentation regarding influenza vaccinations. Resident #32's Hospital Discharge Instructions, dated 01/21/2025, revealed the resident refused the influenza virus vaccine at the hospital. During an interview on 04/17/2025 at 9:53 AM, the Director of Staff Development (DSD), who was also the Infection Preventionist (IP), stated that Resident #32 was not offered the influenza vaccination but that it was the facility expectation that the resident be offered one if they were admitted during the influenza season. During an interview on 04/17/2025 at 10:33 AM, the Director of Nursing (DON) stated that, on admission, staff should have asked about influenza vaccinations if the admission was during the influenza season. The DON stated that, the next day, the IP should have arranged those vaccinations. The DON stated that the DSD was not the IP at the time that Resident #32 was admitted , which was probably why the vaccination was missed. During an interview on 04/17/2025 at 11:08 AM, the Administrator revealed he relied on his IP regarding influenza immunizations, and he was unsure of the facility's expectation. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 12:23 PM, the Case Manager, who is also an IP, stated that when a new resident was admitted , the facility reviewed their record to see what immunizations were received. The Case Manager stated sometimes the facility interviewed the resident in case some immunizations were not available in the medical record. The Case Manager stated if they were unable to find records of an immunization, they re-offered the immunization. The Case Manager stated if the resident wished to receive an immunization, the doctor obtained an informed consent and wrote the order. The Case Manager stated then the facility ordered the vaccine from the pharmacy. The Care Manager stated there was a specific declination form used by the facility and if they saw that an immunization was refused at a hospital, they still obtained the facility declination. The Case Manager stated the reasoning was because the resident may be documented as refusing an immunization for a multitude of reasons and perhaps the immunization was not offered, or the immunization was not explained properly, or the resident did not want an immunization in an acute-care setting. The Case Manager stated it was still the facility's obligation to re-offer an immunization if there was no record that the resident received that immunization.