STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055508	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacob Healthcare Center	4075 54th St. 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review II (PASARR II - a federal requirement to help ensure that individuals with mental disorders were not inappropriately placed in nursing homes for long term care) were conducted for two of five residents (Resident 6 and Resident 99) reviewed for PASARR screening. This failure had the potential for Residents 6 and 99, to be improperly placed and not have received additional qualified services. Findings: 1. Resident 6 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a chronic mental illness that affects how a person thinks, feels, and behaves), per the facility's Admission Record. On 9/12/24, Resident 6's clinical records were reviewed: According to the Minimum Data Set (MDS-a clinical assessment tool), dated 8/1/24, Resident 6 had a cognitive score of 12, indicating cognition was intact. According to the PASARR I Screening, dated 6/10/24, Resident 6 was coded, Positive which indicated a Level II- Mental Health Evaluation was required. According to the Department of Health Care Services letter, dated 6/12/24, the State arrived at the facility and was unable to conduct the PASARR II assessment, because Resident 6 had been discharged to the hospital on 6/10/24. According to the facility's census, Resident 6 returned to the facility on [DATE] and there was no documented evidence the Department of Health Care Services was informed of the return, so the PASARR II could be re-scheduled and conducted. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055508	A. Building B. Wing	09/12/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 9/12/24 at 9:38 A.M. The MDSN stated she was responsible to re-submit the Resident Review PASARR 2 Assessment to the State after a positive PASARR I was found. The MDSN reviewed Resident 6's PASARR status and stated the PASARR II was missed when the resident went to the hospital, and it should have been conducted after he returned. The MDSN stated she missed it and never re-submitted a review to the State. The MDSN stated PASARR II's were important to ensure the facility's placement was appropriate for the resident, and to determine if additional services were needed to ensure a meaningful life. According to the facility's policy titled Admission Criteria, dated March 2019, .9. All new admissions and readmissions are screened for mental disorders (MD) .per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions .to determine if the individual meets the criteria for a MD .b. If the level I screening indicates the individual meets the criteria for an MD .he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process . 2. Resident 99 was admitted to the facility on [DATE], with diagnoses which included unspecified psychosis not due to a substance or known physiological condition, per the facility's Admission Record. On 9/10/24, Resident 99's clinical records were reviewed: According to the Minimum Data Set (MDS-a clinical assessment tool), dated 7/5/24, a cognitive score of 11 was listed, indicating moderately impaired cognition. According to the PASARR I Screening, dated 6/28/24, Resident 99 was coded, Negative which indicated, a Level II- Mental Health Evaluation was not required. According to the physician's orders, dated 8/15/24, the physician indicated a new diagnosis of schizoaffective disorder (a rare mental illness that occurs when someone has both schizophrenia and a mood disorder at the same time), and two psychotropic medications (drugs used to treat mental health disorders), were added. There was no documented evidence Resident 99 had a PASARR I reassessment conducted after the 8/15/24, mental health diagnoses, which would have triggered a PASARR II assessment based on the schizoaffective diagnosis. An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 9/11/24 at 8:39 A.M. The MDSN stated if a new diagnosis of schizophrenia was added, she must repeat a PASARR I, which automatically triggered a PASARR II assessment. The MDSN stated if a PASARR I was not repeated, then it would not be captured until the next quarterly assessment. The MDSN reviewed Resident 99's physician order dated 8/15/24, and the PASARR status. The MDSN stated she was usually informed of new diagnosis at the morning staff meeting, but she cannot recall if she was informed of Resident 99's schizoaffective disorder. The MDSN stated when the schizoaffective diagnosis occurred, she should have repeated a PASARR I, so the State would be informed and conduct a PASARR II. The MDSN stated since Resident 99 had not completed a PASARR II assessment, it was undetermined if he qualified for additional services or if he was correctly placed at this facility. The MDSN stated Resident 99's next quarterly MDS assessment would have been in October 2024, so any additional services would have been delayed. (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 9/12/24 at 9 AM. The DON stated Resident 99 should have been reassessed for a PASARR I, after the diagnoses of schizoaffective disorder. The DON stated a PASARR II would have been triggered and the resident might have qualified for additional mental health services if it had been captured. According to the facility's policy titled Admission Criteria, dated March 2019, .9. All new admissions and readmissions are screened for mental disorders (MD) .per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions .to determine if the individual meets the criteria for a MD .b. If the level I screening indicates the individual meets the criteria for an MD .he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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	055508	A. Building B. Wing	09/12/2024

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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** 50175 Based on interview and record review, the facility failed to develop a resident-centered care plan for one of six residents (Resident 6) when Resident 6's care plan did not include dementia care. This failure had the potential for Resident 6's needs to be unmet. Findings: Resident 6 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (a mood disorder that causes low interest in things that once brought joy) and anxiety disorder (feelings that results in panic attacks), according to the facility's Admission Record. A review of Resident 6's History and Physical (a medical examination that involves a patient interview, physical exam, and documentation of findings), dated 6/15/24, indicated Resident 6 has dementia (loss of cognitive function that affects thinking, remembering, and reasoning) and Resident 6 did not have the capacity to understand and make decisions. A joint interview and record review was conducted with the Director of Nursing (DON) on 9/12/24 at 10:01 A. M. The DON stated according to Resident 6's History and Physical, the resident had a diagnosis of dementia. The DON acknowledged care plan related to Resident 6's dementia was not developed to ensure the resident's care needs were addressed. According to the facility's policy titled Dementia - Clinical Protocol, revised 11/2018, the facility .will identify a resident-centered care plan to maximize remaining function and quality of life .The [interdisciplinary team (a team of staff consisting of multiple disciplines including the physician, nurse, social worker, etc.)] will identify and document the resident's condition and level of support during care planning .Resident needs will be communicated to direct care staff through care plan conferences . According to the facility's policy titled Care Plans, Comprehensive Person-Centered, revised 12/16, indicated A comprehensive, person-centered care plan .includes .objectives .to meet the resident's physical, psychosocial, and functional needs .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 81's) care plan was revised when Resident 81's gastrostomy tube (G-tube, a tube surgically inserted through the belly that brings nutrition directly to the stomach) was discontinued. This failure had the potential for Resident 81's care to be miscommunicated among caregivers. Findings: Resident 81 was admitted to the facility on [DATE], with diagnoses which included traumatic subdural hemorrhage (brain bleed) according to the Admission Record. An observation was conducted on 9/9/24 at 11:55 A.M. in the resident dining hall. Resident 81 was observed feeding himself with a family member present. A review of Resident 81's physician's order, dated 8/22/24, indicated Resident 81 had a diet order for soft textured food. A review of Resident 81's care plan indicated, Resident 81 had a G-tube. Resident 81's care plan indicated check tube feeding residuals (the volume of fluid remaining in the stomach during tube feeding) every shift and to hold tube feeding if residuals was greater than 250 milliliters. An interview was conducted with the Registered Dietitian (RD) on 9/11/24 at 2:31 P.M. The RD stated Resident 81 was exclusively eating by mouth and was no longer on tube feeding. An interview was conducted with Licensed Nurse (LN) 1 on 9/11/24 at 4:02 P.M. LN 1 stated Resident 81 was no longer on tube feedings. LN 1 stated Resident 81's care plan should have been revised since Resident 81 was no longer receiving tube feeding. An interview with the Director of Nursing (DON) was conducted on 9/12/24 at 8:14 A.M. The DON stated that the care plan interventions for Resident 81 were no longer accurate, and that the care plan should have been revised. The DON stated that since Resident 81 was no longer receiving tube feeding, the care plan could cause confusion amongst the staff caring for Resident 81. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised 12/2016, indicated .12. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change .

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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** 50175 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were followed for three of eight residents (Resident 5, Resident 6, and Resident 18) when: 1. A resident (Resident 5) was newly diagnosed at the facility with schizophrenia (a chronic mental illness characterized by delusions and hallucinations), without meeting the criteria for schizophrenia as indicated by The Diagnostic and Statistical Manual of Mental Disorders (DSM, a reference manual from the American Psychiatric Association to help define and classify mental disorders). 2. A resident (Resident 6) was newly diagnosed at the facility with schizophrenia without meeting the criteria for schizophrenia as indicated by the DSM. 3. A licensed nurse (LN 32) did not obtain the heart rate of Resident 18 prior to administering two blood pressure medications. This failure had the potential for Resident 5, Resident 6, and Resident 18 to experience unnecessary medication side effects. (Cross Reference F758) Findings: 1. Resident 5 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental condition causing intense feelings of fear and anxiety) and major depressive disorder (a mental illness causing persistent feelings of sadness) according to the Admission Record. A review of Resident 5's physician's order, dated 1/19/24, indicated an order for Seroquel (an antipsychotic medication) for schizophrenia as evidenced by indifference to surroundings manifested by pulling at life sustaining devices. An interview was conducted on 9/11/24 at 9:16 A.M. with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 5 had no hallucinations. A telephone interview was conducted on 9/12/24 at 8:35 A.M. with Responsible Party (RP) 1. RP 1 stated Resident 5 had no history of schizophrenia. RP 1 stated Resident 5 had a history of anxiety and thought that Seroquel was being given for Resident 5's anxiety. RP 1 stated the psychiatrist never mentioned schizophrenia, and that no one informed her Resident 5 had a diagnosis of schizophrenia. A review of Resident 5's progress note written by LN 7, dated 4/4/23 at 2:50 P.M., indicated Resident 5 was admitted with Seroquel .with no appropriate diagnosis . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview and record review was conducted with the Director of Nursing (DON) and Social Worker (SW) 1 on 9/12/24 at 10:55 A.M. SW 1 stated Resident 5 received Seroquel in the hospital for pulling her tracheostomy tube (a tube surgically inserted in the neck to help someone breathe). SW 1 stated there was no diagnosis of schizophrenia from the hospital. The DON and SW 1 stated Medical Doctor (MD) 1 diagnosed Resident 5 with schizophrenia based on Resident 5's behavior of pulling tubes. The DON and SW 1 stated there was no documentation in Resident 5's medical record that indicated that the resident experienced hallucinations. The DON stated the physician's orders for Resident 5's Seroquel indicated that the medication was to be given for schizophrenia as evidenced by .indifference to surroundings manifested by pulling at life sustaining devices . The DON stated she had not seen an order for pulling life sustaining tubes as the only indication for schizophrenia and would have questioned the order if she had been aware. The DON stated she expected to see auditory hallucinations (hearing things that not there), visual hallucinations (seeing things that are not there), or delusions (a false belief, not reality) as an indication for schizophrenia. The DON further stated there were no physician's orders for non-pharmacological interventions (healthcare treatment without medications) before the use of Seroquel which was important to determine if Seroquel was needed for Resident 5. The DON stated RP 1 should have been made aware of Resident 5's schizophrenia diagnosis. The DON stated Resident 5's schizophrenia diagnosis did not follow the guidance provided in the DSM. A telephone interview was conducted on 9/12/24 at 2:21 P.M. with MD 2. MD 2 stated he did not get involved with psychiatry diagnoses. An interview was conducted on 9/12/24 at 1:20 P.M. with the Administrator (ADM). The ADM stated the DON was unable to reach MD 1 via phone to request information regarding Resident 5's schizophrenia diagnosis. On 9/12/24 at 1:34 P.M., a phone call was placed to MD 1 with no answer. A voicemail message was left with a call back number. There was no response received from MD 1. According to the DSM version 5, .Schizophrenia is characterized by delusions, hallucinations, disorganized speech and behavior .For a diagnosis, symptoms must have been present for six months . A review of the facility's policy titled Antipsychotic Medication Use, revised 12/2016, indicated .Antipsychotic medications shall generally be used for the following conditions/diagnoses .consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders [DSM] .schizophrenia .Diagnoses alone do not warrant the use of antipsychotic medications .antipsychotic medications will generally only be considered if . behavioral interventions have been attempted . A review of the facility's policy titled Conformity with Laws and Professional Standards, revised 4/2017, indicated Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accepted health standards established by national organizations, boards, and councils . 2. Resident 6 was admitted to the facility on [DATE] with diagnoses including anxiety disorder and major depressive disorder according to the Admission Record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 6's physician's order, dated 7/9/24, indicated an order for Seroquel for schizophrenia as evidenced by unprovoked agitation. An interview was conducted on 9/11/24 at 9:56 A.M. with Licensed Nurse (LN) 3. LN 3 stated Resident 6 was alert, oriented, and compliant with care. LN 3 stated Resident 6 was on Seroquel for schizophrenia. A joint interview with Resident 6 and CNA 2 was conducted on 9/11/24 at 12:12 P.M. in Resident 6's room. Resident 6 stated he has anxiety, but not schizophrenia. Resident 6 stated he was taking Seroquel for anxiety. CNA 2 stated Resident 6 was alert and did not have any hallucinations. A review of Resident 6's History and Physical (a medical examination that involves a patient interview, physical exam, and documentation of findings), dated 4/30/24, indicated Resident 6 had the capacity to understand and make decisions. A joint interview and record review with the DON and SW 1 was conducted on 9/12/24 at 10:21 A.M. SW 1 stated Resident 6 received Seroquel for agitation while in the hospital. SW 1 stated MD 1's progress note, dated 5/2/24, indicated Resident 6 had auditory hallucinations and paranoia (unrealistic distrust of others). The DON stated there were no nursing documentation found on Resident 6's medical record that indicated Resident 6 experienced hallucinations and paranoia. The DON stated Resident 6's Seroquel was ordered for unprovoked agitation. The DON further stated there were no physician's orders for non-pharmacological interventions before the use of Seroquel which was important to determine if Seroquel was needed for Resident 6. The DON stated Resident 6's schizophrenia diagnosis did not follow the guidance provided in the DSM. An interview was conducted on 9/12/24 at 1:20 P.M. with the Administrator (ADM). The ADM stated the DON was unable to reach MD 1 via phone to request information regarding Resident 6's schizophrenia diagnosis. On 9/12/24 at 1:34 P.M., a phone call was placed to MD 1 with no answer. A voicemail message was left with a call back number. There was no response received from MD 1. According to the DSM version 5, .Schizophrenia is characterized by delusions, hallucinations, disorganized speech and behavior .For a diagnosis, symptoms must have been present for six months . A review of the facility's policy titled Antipsychotic Medication Use, revised 12/2016, indicated .Antipsychotic medications shall generally be used for the following conditions/diagnoses .consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders [DSM] .schizophrenia .Diagnoses alone do not warrant the use of antipsychotic medications .antipsychotic medications will generally only be considered if . behavioral interventions have been attempted . A review of the facility's policy titled Conformity with Laws and Professional Standards, revised 4/2017, indicated .Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accepted health standards established by national organizations, boards, and councils . 49330 (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 18 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and atrial fibrillation (an irregular heartbeat) according to the Admission Record. On 9/11/24 at 8:40 A.M., an observation of a medication pass was conducted with Licensed Nurse (LN) 23. LN 23 was observed taking Resident 18's blood pressure. LN 23 stated Resident 18 had a blood pressure reading of 119/70. LN 23 was observed giving Resident 18 lisinopril 10 milligrams (mg) and diltiazem 240 mg, two medications that work by lowering blood pressure. On 9/11/24 at 8:48 A.M., a concurrent interview and record review was conducted with LN 23. LN 23 was observed documenting in Resident 18's electronic Medication Administration Record (eMAR). LN 23 stated the instructions for Resident 18's blood pressure medications were .Hold if SBP (the top number of the blood pressure reading) is less than 110 .and/or HR (heart rate) is less than 60 BPM (beats per minute) . LN 23 stated .I may have made a mistake .I completely skipped checking the pulse [heart rate] . LN 23 stated it was important to check Resident 18's heart rate prior to giving the blood pressure medications because .We don't want her pulse to go lower than 60 .she can have a change of condition . On 9/12/24 at 9:25 A.M. an interview was conducted with the DON. The DON stated her expectation was for the licensed nurses to obtain all pertinent vital signs prior to administering any medication. The DON stated Resident 18 was at risk for fainting because she was given blood pressure medications without having her pulse checked. A review of the facility policy titled Administering Medications, revised April 2019 indicated, .The following information is checked/verified for each resident prior to administering medications .Vital signs, if necessary . A review of the facility's policy titled Conformity with Laws and Professional Standards, revised 4/2017, indicated .Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accepted health standards established by national organizations, boards, and councils .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49330 Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL - basic and everyday skills that are essential to living independently) were provided to two of three residents (Resident 28 and Resident 30) reviewed for ADL care when: 1. Resident 28 were not provided with incontinence (loss of bladder and/or bowel control) care in a timely manner and, 2. Resident 30 was not provided with nail care. This deficient practice placed Resident 28 and Resident 30 at risk for skin breakdown and decreased quality of life. Findings: 1. According to the Admission Record, Resident 28 was admitted on [DATE] with diagnoses which included quadriplegia (inability to use both arms and legs), need for assistance with personal care, and personal history of urinary tract infections. A review of Resident 28's Minimum Data Set (MDS, an assessment tool), dated 10/1/23 indicated, a BIMS (Brief Interview of Mental Status - a tool to assess cognition) score of 3. According to the BIMS scoring, a score of 0-7 indicated severe mental impairment. The MDS also indicated that Resident 28 was dependent on others for personal hygiene. On 9/9/24 at 8:45 A.M., an observation was made in Resident 28's room. Resident 28 was in bed laying on foul smelling, dark brown substance. Resident 28's brief was also visibly wet. On 9/9/24 at 9:44 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 33. CNA 33 stated she was the assigned CNA for Resident 28. CNA 33 stated she conducted rounds at 7:15 A.M., and noticed Resident 28 had a bowel movement and needed to be changed. CNA 33 stated .I'm not gonna lie, I saw it this morning but I had a sling under another resident who was going to take a shower . On 9/12/24 at 9:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 28 should have been provided with incontinent care in a timely manner. The DON stated CNA 33 . should have asked for assistance or priorized better . The DON stated delaying incontinent care placed Resident 28 at risk for skin breakdown, wounds, or infection. A review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised 3/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with: hygiene (.grooming .), .elimination (toileting) . (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 30 was admitted to the facility on [DATE] with diagnoses which included paraplegia (inability to move the lower part of the body), muscle weakness, and need for assistance with personal care, according to the Admission Record. A review of Resident 30's MDS dated [DATE] indicated Resident 30 had a BIMS score of 15, indicating cognition was intact. The MDS also indicated, Resident 30 was dependent with personal hygiene. On 9/9/24 at 9:31 A.M., a concurrent observation and interview was conducted with Resident 30. Resident 30 was laying in bed, on her back. Resident 30 had pillows under her legs and was not wearing socks. Resident 30's toenails appeared long with jagged edges. Resident 30 stated she did not want to wear socks because her toenails were .too long . Resident 30 stated she has asked staff to trim her toenails, but nobody has done it yet. Resident 30 stated I feel embarrassed about my toenails, they have never been this long before . Resident 30 stated her family members had cut her toenails for her, but they were no longer able to. On 9/9/24 at 9:44 A.M., an interview was conducted with CNA 33. CNA 33 stated nail clippers and files were available for CNAs to use, but she was not sure whether CNAs could trim residents' nails. On 9/12/24 at 9:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated CNA's were able to trim resident's toenails and .it depends on the resident's preference . The DON stated .I prefer a licensed nurse (cut residents' toenails) but if the resident wants it done, it should be done . The DON stated residents with untrimmed nails were prone to skin tears or infections. A review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised 3/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with: hygiene (.grooming .), .elimination (toileting) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055508	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview and record review, the facility failed to ensure a safe environment was maintained when side rails were not installed for one of one residents (Resident 28) reviewed for side rails. As a result, there was a potential for Resident 28 to sustain injury. Findings: According to the Admission Record, Resident 28 was admitted to the facility on [DATE] with diagnoses which included functional quadriplegia (the inability to move due to severe physical disability or frailty) and epilepsy (a disorder which causes seizures). A review of Resident 28's Minimum Data Set (MDS, an assessment tool), dated 10/1/23 indicated, a BIMS (Brief Interview of Mental Status) score of 3. According to the BIMS scoring, a score of 0-7 indicated severe mental impairment. On 09/09/24 at 8:45 A.M. an observation was made in Resident 28's room. Resident 28 was laying in bed with her bed pushed up against the wall. There were no side rails observed on Resident 28's bed. A review of Resident 28's Side Rail Assessment, dated 11/28/23, indicated, .Put 1/4 bilateral bed rails up when in bed .To assist resident in bed mobility and/or transfers .For unstable trunk control for support when head of bed is elevated .For safety .(related to diagnosis Epilepsy) . A review of Resident 28's Physician's Order dated 9/9/24 indicated, .Put 1/2 bilateral side rails up when in bed .To assist resident in bed mobility and/or transfers .For unstable trunk control for support when head of bed is elevated .(for) safety . On 9/12/24 at 9:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 28 was moved from a different room and (Resident 28)'s side rails did not come with her . The DON stated her expectation was for the licensed nurse to see the order for side rails and to ensure it was installed on Resident 28's bed. The DON stated the side rails were for .function and safety .whoever was doing the room change should've made sure the side rail came with the resident, or new ones installed on her bed . The DON stated Resident 28 was provided with side rails for safety if she had a seizure. The DON stated the delay in not having side rails could have caused injury for the resident, including falls. A review of the facility policy titled Proper Use of Side Rails, revised December 2016, indicated, .The resident will be checked periodically for safety relative to side rail use .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to implement non-pharmacological interventions (NPIs - ie. positioning, dark room, ice/heat, massage), as ordered by the physician, prior to the administration of PRN (as needed) pain medications for three of three residents (Residents 22, 99 and 312) reviewed for pain management. This failure had the potential for Residents 22, 99 and 312 not to receive non-prescription pain relief, prior to receiving narcotic pain medications with added side effects. Finding: 1. Resident 22 was admitted to the facility on [DATE], with diagnoses which included chronic pain syndrome (when a person experiences persistent pain that interferes with daily life), per the facility's Admission Record. On 9/11/24, Resident 22's clinical records were reviewed: According to the Minimum Data Set (MDS-a clinical assessment tool), Resident 22 had a cognitive score of 15, indicating cognition was intact. The section titled, Health Condition, indicated, Resident 22 received scheduled and as needed pain medications. According to the physician orders, dated 10/20/23, .Oxycodone (a synthetic pain relief drug) 10 milligrams (mg) by mouth every 4 hours as needed for moderate to severe pain (pain scale 4-10, [scale of 0 indicates no pain, and 10 being the worst pain]) .Tylenol 325 mg two tablets by mouth every 4 hours as needed for mild pain .Prior to administering PRN pain medication (Tylenol, Oxycodone) document any/all interventions completed by entering the number that describes action taken. Non-Pharmacological Approaches to prn pain medications, 1. Re-positioning 2. Dim light/Quiet the Environment 3. Snacks/Drinks 4. Hand holding 5. Re-Direct 6. Music 7. Massage 8. Other every 4 hours as needed . The Medication Administration Record (MAR) was reviewed from September 1, 2024, through September 11, 2024. Oxycodone was administered three times. There was no documented evidence NPIs were attempted prior to the administration of Oxycodone. According to the care plan, titled Pain, undated, interventions included, .Provide Non-Pharmacological interventions: >Turn and reposition>Dim lights/quite environment>Relaxation techniques>Music>Massage>Distraction . The facility's Pain Assessment interview, dated 8/9/24, Section C- asked: What made the pain better? Resident 22 answered Medication, turning and repositioning. 2. Resident 99 was admitted to the facility on [DATE], with diagnoses which included orthopedic aftercare following surgical amputation, per the facility's Admission record. On 9/10/24, Resident 99's clinical records were reviewed: (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS, dated [DATE], Resident 99 had a cognitive score of 11, indicating cognition was moderately impaired. The section titled, Health Condition, indicated Resident 99 received scheduled and as needed pain medications. According to the physician orders, dated, 6/28/24, .Tramadol (a medication used to treat moderate to severe pain), 50 mg, by mouth every 6 hours as needed for severe pain (scale 7-10) .Acetaminophen (Tylenol), 325 mg, give 2 tablets by mouth every 4 hours as needed for mild pain 1-3/10 .Non-Pharmacological Interventions prior to PRN pain medication administration. 1. Reposition/limb elevation 2. Dim lights/quite environment/Rest periods 3. Snacks/drink 4. Therapeutic touch/Massage is not contraindicated 5. Redirect/reassurance/emotional support 6. Music 7. Guided imagery/meditation 8. Provide distraction/diversionary activities 9. Exercise/Range of Motion/ambulation/stretching 10. Deep breathing/relaxation exercises 11. Laughter/socialization 12. Other (describe) every 4 hours as needed for pain . The MAR was reviewed from September 1, 2024, through September 10, 2024. Tramadol was administered 17 times. Two of the 17 times, Resident 99 had a recorded pain level of 5 (Below the scale indicated by physician 7-10). There was no documented evidence any non-pharmacological interventions were attempted, prior to the administration of Tramadol. According to the care plan, titled Pain, interventions included, .Provide non-pharmacological measures/Non Drug interventions prior to giving pain medications . The facility's Pain Assessment Interview, dated 6/18/24, was incomplete and did not indicate what made the pain better or worse, or where the pain was located. 3. Resident 312 was admitted to the facility on [DATE], with diagnoses which included rectal cancer, per the facility's Admission Record. On 9/11/24, Resident 312's clinical records were reviewed: The Admission Minimum Data Set (MDS - an assessment tool) was, In Progress, and had not yet been completed. According to the physician orders, .Oxycodone 10 mg, give 1 tablet by mouth every 8 hours as needed for Breakthrough Pain. Administer as needed for pain scale 7-10) .Acetaminophen (Tylenol) 325 mg, give two tablets by mouth every 4 hours as needed for mild pain (1-3) non-drug interventions prior to administering PRN 1. Reposition 2. Distraction 3. Breathing techniques 4. Gentle Massage 5. Relaxation technique 6. Music 7. Other . The MAR was reviewed from September 6, 2024, through September 11, 2024. Oxycodone was administered seven times. There was no documented evidence any non-pharmacological interventions were attempted prior to the administration of Oxycodone. According to the care plan, titled Pain, undated, interventions included, .Provide non-pharmacological measures/Non Drug interventions prior to giving pain medications . The facility's Pain Assessment Interview, dated 9/6/24, was incomplete and did not indicate what made the pain better or worse, or where the pain was located. (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with certified nursing assistant (CNA) 11 on 9/10/24 at 2:22 P.M. CNA 11 stated if a resident complained of pain she would first obtain their vital signs (blood pressure, heart rate, respirator rate) and then attempt to make them comfortable by re-positioning them, or dimming the light, until the licensed nurse (LN) could come in and assess them for pain. An interview and record review was conducted with Licensed Nurse (LN) 11 on 9/10/24 at 2:27 P.M. LN 11 stated non-pharmacological interventions (NPIs) should always be attempted before administering pain medications. LN 11 stated the NPIs may help alleviate the pain, so the narcotic might not be needed. LN 11 stated there were side effects when taking narcotics such as constipation, decreased respiratory rates, and decreased movement. LN 11 stated if the physician ordered NPIs before PRN pain medications were given, then the NPIs should be performed and documented. LN 11 reviewed Resident 99's September MAR and stated no NPIs were documented prior to the resident receiving the PRN pain medications. An interview was conducted with the Director of Staff Development (DSD) on 9/10/24 at 2:37 P.M. The DSD stated NPIs were important because it was important to attempt holistic approaches first. The DSD stated if the NPIs were helpful, the pain medications might not be required. The DSD stated if the physician ordered NPIs, then the orders needed to be followed by staff. The DSD stated if nurses were not attempting NPIs, they were not following the physician's plan of care. An interview was conducted with the Director of Nursing (DON) on 9/12/24 at 9:00 A.M. The DON stated NPIs should be attempted prior to administering pain medications, and she expected staff to document the attempted NPIs, so other staff were aware of what worked. The DON stated by not attempting NPIs, staff were unaware if the NPIs might have alleviated the pain, so the pain medication might not have been needed. The DON stated if the physician wrote an order to do NPIs prior to medicating for pain, she expected the licensed nurses to attempt the NPIs. According to the facility's policy, titled Pain Assessment and Management, dated October 2022, . Implementing Pain Management Strategies: .2. Non-pharmacological interventions may be appropriate alone or in conjunction with medications .a. Environment .b. physical .c. exercise .d. cognitive or behavioral .

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	055508	A. Building B. Wing	09/12/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review the facility failed to provide dialysis (treatment to remove waste from the body) access care, including removal of dressing from the dialysis site for one of one sampled residents (Resident 71) reviewed for dialysis. As a result, there was a potential for complications after dialysis. Findings: According to the Admission Record, Resident 71 was admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste) and dependence on dialysis. On 9/9/24 at 9:49 A.M., an observation and interview was conducted with Resident 71. Resident 71's dialysis access site was on the left upper arm. There was a pressure dressing taped over the dialysis access site. Resident 71 stated he went to dialysis treatments on Tuesdays, Thursdays, and Saturdays. On 9/9/24 at 10:01 A.M., an interview was conducted with Licensed Nurse (LN) 35. LN 35 stated Resident 71's last dialysis treatment was on 9/7/24. LN 35 stated the pressure dressing should have been removed four hours after returning to the facility from dialysis. LN 35 stated it was important to remove the pressure dressing to visualize the dialysis site to check for redness or signs of bleeding. LN 35 stated (The dialysis site) can get infected and cause sepsis. If it is on too long it can affect the blood flow of the fistula [dialysis access site] . A review of Resident 71's Physician's Orders indicated, DIALYSIS: Remove pressure dressing from [dialysis access site] 4 hours post-dialysis . On 9/12/24 at 9:25 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated Resident 71's dialysis pressure dressing should have been removed by a licensed nurse four hours after the resident returned from dialysis. The DON stated if the pressure dressing is not removed, .bleeding or infection can arise . A review of the facility policy titled Care of Resident Receiving Renal Dialysis, revised 9/2014, indicated, . Complete post-dialysis assessment on return from treatment .

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	055508	A. Building B. Wing	09/12/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47466 Based on interviews and record reviews, the facility failed to provide sufficient staffing to meet care needs, when call lights were not answered timely for three of six confidential residents (CR 1, 2, 3) interviewed for sufficient staffing. This failure had the potential to result in residents' needs not being met, which had the potential to result in physical and psychosocial harm. Findings: On 9/9/24, a review of the offsite survey record indicated, the facility had low weekend staffing on the 3rd quarter of 2024. An interview on 9/9/24 at 8:27 A.M., with CR 2 was conducted. CR 2 stated he had a left heel wound and cannot see well. CR 2 stated he needed assistance in going to the bathroom, transfers, or going to bed. CR 2 stated staff ignored his call light when he needed help. Staff came and turned off the call light. On 9/10/24 at 10:13 A.M., a confidential meeting with the residents was conducted. Two of five residents have identified issues with call light response. 1. CR 2 stated it took a lot of time for call lights to get answered especially on the evening shift (3pm - 11pm). CR 2 stated there were only 2 CNAs in the afternoon shift, so if one CNA was giving a shower, it would take a while for his call light to get answered. CR 2 also stated, he would tell staff not to turn off his call light until they return, but staff forgot about him. CR 2 also stated The facility needed more staff in the morning and evening shift because they have a lot to do. 2. On 9/10/24 at 10:45 A.M., CR 3 stated staff would answer his call light and helped him if he needed to use the bathroom, but for other needs, staff would let him wait. A review of the Resident Council minutes for the month of June, July, and August 30, 2024, indicated call light response and insufficient staffing issues were repeatedly identified. An interview on 9/11/24 at 2:50 P.M., with licensed nurse (LN) 23 was conducted. LN 23 stated she started nine months ago and noticed the facility had call light issues. LN 23 stated we tried to keep with the residents' needs, but sometimes it was not feasible. LN 23 stated we had an in services recently regarding call lights response, but still, we have complaints from our residents. An interview on 9/12/24 at 9:16 A.M., with the Staffing Coordinator (SC) was conducted. The SC stated we tried to call staff who are off on those days, and staffing was also based on the facility's census. The SC stated LNs do CNA work when short of CNA assistance. On 9/12/24 at 3:00 P.M., an interview and review of the facility's daily shift assignments for the weekends of April, May and June 2024 was conducted with the Director of Staff Development (DSD). (continued on next page)

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	055508	A. Building B. Wing	09/12/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For the month of April 2024: On 4/7, afternoon shift (3pm - 11pm), a LN called off. No replacement. For the month of May 2024: On 5/27, afternoon shift (3pm - 11pm), a certified nursing assistant (CNA) called off. No replacement. For the month of June 2024: On 6/9, afternoon shift (3pm - 11pm), a CNA and a LN called off. No replacement. On 6/9, night shift (11pm - 7am), a CNA and a LN called off. No replacement. On 6/22, afternoon shift (3pm - 11pm), a CNA worked for two hours only from 3pm - 5pm. On 6/23, morning shift (7am - 3pm), a LN called off. No replacement On 6/30, afternoon shift (3pm - 11pm), a restorative nursing aide (RNA) only worked four hours from 3 P.M. to 7 P.M. On 9/12/24 at 3:45 P.M., an interview with the Administrator (ADM) was conducted. The ADM stated if a staff called off, the Director of Nursing (DON) tried to call for a replacement. The ADM stated we have low staffing on the weekends because everyone wanted to be off on the weekends and we have not use registry that often. An interview on 9/12/24 at 3:55 P.M., with the DON was conducted. The DON stated she was aware of the call offs especially on the weekends and the concerns from the resident council regarding repeated staffing issues and call lights. A review of the facility's patient needs waiver to title 22 indicated the facility request was approved from July 1, 2024 to June 30, 2025. The record indicated, . #2 the facility shall continue to provide a minimum of 3.5 direct care service hours per patient per day. 3# .when the facility cannot provide 2.4 cna direct care service hours per patient per day, the facility shall use licensed vocational nurses and or registered nurses. A record review of the facility's policy on staffing dated October 2017 indicated . policy interpretation #1 licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 39111 3. A confidential interview was conducted with confidential resident (CR) 1. CR 1 stated it often took over one hour to get help being changed after an incontinence episode. CR 1 stated this mostly occurred in the daytime. CR 1 stated she did not think there was enough staff to answer the call lights and provide help in a timely manner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A confidential staff interview was conducted with confidential staff (CS) 2. CS 2 stated with all the gowning up (putting on personal protective equipment such as gowns, gloves, and/or masks) for isolation precautions, added respiratory therapy tasks such as suctioning residents and providing breathing treatments, nursing staff had difficulty answering the call lights in a timely manner. CS 2 stated there needed to be more nursing staff on the subacute unit as the majority of the residents had higher acuity (more medical attention/needs) and required two or more staff to provide total care (residents cannot participate in the care due to a medical condition). CS 2 stated staff for subacute unit did not answer call lights or provide care on subskilled. On 9/11/24 at 2:26 P.M., an observation was conducted on the subacute and subskilled units. The call light went on in Room A and was accompanied by the banging sound of an object on the overbed table. Two respiratory therapists (RT) were observed engaged in conversation directly across from Room A. At 2:30 P. M., the RTs were observed walking away from Room A without answering the call light. When the RTs walked away a licensed nurse was observed putting on PPE to go into Room A to answer the resident's call light. On 9/11/24 at 2:30 P.M., an interview was conducted with RT 1. RT 1 was asked about Room A's call light and banging sounds while she and another RT were outside the room and observed not answering the resident's call light. RT 1 stated she was in the zone and did not notice the resident's call light or banging sounds. RT 1 stated everyone was responsible for answering the call light. On 9/11/24 at 2:40 P.M., an interview was conducted with certified nursing assistant (CNA) 100. CNA 100 stated she worked on the subskilled unit and that answering the call light timely could be difficult. CNA 100 stated while the subskilled unit was visible from the subacute nursing station, the subacute staff did not answer the call lights on the subskilled unit. CNA 100 stated if the staff on the subskilled were busy in resident rooms and a call light was on, they would not know until they stepped into the hallway to see the call light. CNA 100 stated the subskiled unit was under the supervision of the nurse on the Moss unit (located on the other side of the facility) and she was not sure if the charge nurse on Moss could see the call lights that were on on the subskilled unit. CNA 100 stated if they needed assistance on the subskilled unit, they would have to ask the charge nurse on the subacute unit to phone over to the Moss unit to request help. A record review of the facility 's patient needs waiver to title 22 indicated the facility request was approved from July 1, 24 to June 30, 25. The record indicated .#2 the facility shall continue to provide a minimum of 3. 5 direct care service hours per patient per day. #3 .when the facility cannot provide 2.4 cna direct care service hours per patient per day, the facility shall use licensed vocational nurses and or registered nurses. A record review of the facility's policy on staffing dated October 2017 indicated . policy interpretation #1 licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.

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	055508	A. Building B. Wing	09/12/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on interview and record review, the facility failed to ensure two of five residents (Resident 5 and Resident 6) were free from unnecessary medications when Resident 5 and Resident 6 were given antipsychotic medications (medication to treat psychosis) without clear indications. This failure had the potential for Resident 5 and Resident 6 to experience unnecessary medication side effects. Cross Reference F658 Findings: 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder (a mental condition causing intense feelings of fear and anxiety) and major depressive disorder (a mental illness causing persistent feelings of sadness) according to the Admission Record. A review of Resident 6's physician's order, dated 7/9/24, indicated an order for Seroquel (an antipsychotic medication) for schizophrenia as evidenced by unprovoked agitation. An interview was conducted on 9/11/24 at 9:56 A.M. with Licensed Nurse (LN) 3. LN 3 stated Resident 6 was alert, oriented, and compliant with care. LN 3 stated Resident 6 was on Seroquel for schizophrenia. A joint interview with Resident 6 and Certified Nursing Assistant (CNA) 2 was conducted on 9/11/24 at 12:12 P.M. in Resident 6's room. Resident 6 stated he had anxiety, but not schizophrenia. Resident 6 stated he was taking Seroquel for anxiety. CNA 2 stated Resident 6 was alert and did not have any hallucinations. A review of Resident 6's History and Physical (a medical examination that involves a patient interview, physical exam, and documentation of findings), dated 4/30/24, indicated Resident 6 had the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview and record review with the Director of Nursing (DON) and Social Worker (SW) 1 was conducted on 9/12/24 at 10:21 A.M. SW 1 stated Resident 6 received Seroquel for agitation while in the hospital. SW 1 stated Medical Doctor (MD) 1's progress note, dated 5/2/24, indicated Resident 6 had auditory hallucinations (hearing things that are not there) and paranoia (unrealistic distrust of others). The DON stated there were no nursing documentation found in Resident 6's medical record that indicated Resident 6 experienced hallucinations and paranoia. The DON stated Resident 6's order for Seroquel was for unprovoked agitation which was not an appropriate indication for the use of Seroquel. The DON further stated there were no physician's orders for non-pharmacological interventions (healthcare treatment without medications) before the use of Seroquel which was important to determine if Seroquel was needed for Resident 6. The DON stated Resident 6's schizophrenia did not follow the guidance provided in the The Diagnostic and Statistical Manual of Mental Disorders (DSM, a reference manual from the American Psychiatric Association to help define and classify mental disorders). 2. Resident 5 was admitted to the facility on [DATE] with diagnoses including anxiety disorder and major depressive disorder according to Resident 5's Admission Record. A review of Resident 5's physician's order, dated 1/19/24, indicated an order for Seroquel for schizophrenia as evidenced by indifference to surroundings manifested by pulling at life sustaining devices. An interview was conducted on 9/11/24 at 9:16 A.M. with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 5 had no hallucinations. A telephone interview was conducted on 9/12/24 at 8:35 A.M. with Responsible Party (RP) 1. RP 1 stated Resident 5 had no history of schizophrenia. RP 1 stated Resident 5 had a history of anxiety and thought Seroquel was given for Resident 5's anxiety. RP 1 stated the psychiatrist never mentioned schizophrenia, and that no one informed her Resident 5 had a diagnosis of schizophrenia. A review of Resident 5's progress note written by LN 7, dated 4/4/23 at 2:50 P.M., indicated Resident 5 was admitted with Seroquel .with no appropriate diagnosis . A joint interview and record review was conducted with the DON and SW 1 on 9/12/24 at 10:55 A.M. SW 1 stated Resident 5 received Seroquel in the hospital for pulling the tracheostomy tube (a tube surgically inserted in the neck to help someone breathe). SW 1 stated there was no diagnosis of schizophrenia from the hospital. The DON and SW 1 stated MD 1 diagnosed Resident 5 with schizophrenia based on Resident 5's behavior of pulling tubes. The DON and SW 1 stated there were no documentations in Resident 5's medical record that the resident experienced hallucinations. The DON stated the physician's orders for Resident 5's Seroquel indicated that the medication was to be given for schizophrenia as evidenced by .indifference to surroundings manifested by pulling at life sustaining devices . The DON stated she had not seen an order for pulling life sustaining tubes as the only indication for schizophrenia and would have questioned the order if she had been aware. The DON stated she expected to see auditory hallucinations, visual hallucinations (seeing things that are not there), or delusions (a false belief, not reality) as an indication for schizophrenia. The DON further stated there were no physician's orders for non-pharmacological interventions before the use of Seroquel which was important to determine if Seroquel was needed for Resident 5. The DON stated RP 1 should have been made aware of Resident 5's schizophrenia diagnosis. The DON stated Resident 5's schizophrenia diagnosis did not follow the guidance provided in the DSM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055508	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacob Healthcare Center	4075 54th St. San Diego, CA 92105

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/12/24 at 1:20 P.M. with the Administrator (ADM). The ADM stated the DON was unable to reach MD 1 via phone to request information regarding Resident 5 and Resident 6's schizophrenia diagnosis. On 9/12/24 at 1:34 P.M., a phone call was placed to MD 1 with no answer. A voicemail message was left with a call back number. There was no response received from MD 1. A review of the facility's policy titled Antipsychotic Medication Use, revised 12/2016, .Antipsychotic medications shall generally be used for the following conditions/diagnoses .consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders [DSM] .schizophrenia .Diagnoses alone do not warrant the use of antipsychotic medications .antipsychotic medications will generally only be considered if . behavioral interventions have been attempted .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review, the facility failed to ensure that it was free of a medication error rate of five percent or greater when two routine medications were not available for one of three sampled residents (Resident 72) observed for medication administration. This failure had the potential to negatively affect Resident 72's health. Findings: According to the Admission Record, Resident 72 was admitted to the facility on [DATE] with diagnoses which included nutritional anemia (low red blood cells caused by a lack of either iron, protein, or vitamin B12), and muscle weakness. On 9/11/24 at 9:51 A.M., an observation of a medication pass was conducted with Licensed Nurse (LN) 34. LN 34 was observed preparing, then administering Resident 72's 9 A.M. medications. A review of Resident 72's physician's orders indicated, cyanocobalamin (a vitamin used to prevent and treat low levels of vitamin B12) 5000 micrograms one capsule and Calcium 500 milligrams were due to be given every morning at 9 A.M., but were omitted from the medication pass. On 9/11/24 at 3:21 P.M., an interview was conducted with LN 34. LN 34 stated he did not administer the two medications because the medications were not available. LN 34 stated, We have Oyster Shell Calcium, but not Calcium by itself. LN 34 stated he was not sure if Oyster Shell Calcium was the same as Calcium without oyster shell. LN 34 also stated cyanocobalamin 1000 micrograms was available, but not 5000 micrograms. LN 34 stated he informed central supply, but he did not inform the physician or the resident that the medications were unavailable and not given. On 9/12/24 at 9:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important for Resident 72 to receive all his medications. The DON further stated staff should have clarified the orders for B12 and calcium. The DON stated they shouldn't just sign it as not given .the doctor should have been called for guidance . A review of the facility's policy titled Administering Medications, revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed .If a dosage is believed to be inappropriate . the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50175 Based on interview and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify concerns related to unnecessary use of antipsychotic (drug used to treat clinical psychiatric symptoms or mental disorders) medication due to lack of indications. This failure had the potential for deficiencies to remain uncorrected and could result in residents being exposed to unnecessary medication side effects. (Cross reference F758) Findings: An interview was conducted on 9/12/24 at 4:17 P.M. with the Administrator (ADM), the Director of Nursing (DON), and Administrator in Training (AIT) regarding the facility's QAPI committee and their plans. The DON stated the psychotropic committee met to perform gradual dose reductions (GDR, a process of lowering the dose of psychotropic medications) and complete a Medication Review Regimen (MRR, a process to review any issues with ordered medications) for all residents on psychotropic medications. The information gathered from the psychotropic committee was then brought to QAPI. The DON acknowledged there was more to psychotropic review than GDR and MRR. The DON stated the indication for use of psychotropic medications, or the appropriateness of the psychotropic medications was not discussed in the committee or in QAPI. The DON stated psychotropic review should include residents who had psychotropics continued when discharged from the hospital and had a new diagnosis of schizophrenia. The DON and ADM stated the review of psychotropic use in the facility should have been expanded to include a more thorough review and discussion, and not just focus on GDR and MRR. The ADM stated more could have been done to identify the possibility of unnecessary use of psychotropic medications. A review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 2/2020, indicated .The objectives of the QAPI Program are to .2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators .

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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** 49330 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP, the use of gowns, gloves, and face mask during resident care to prevent the transmission of bacteria) for one of four residents (Resident 211) reviewed for infection control. This failure had the potential to spread infectious organisms to Resident 211 and others. Findings: According to the Admission Record, Resident 211 was admitted on [DATE] with diagnoses which included chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys). On 9/9/24 at 9:01 A.M., an observation was conducted inside Resident 211's room. Licensed Nurse (LN) 32 was observed wearing full Personal Protective Equipment (PPE, gown gloves and a mask) while providing care to Resident 211. There was no sign posted outside the room indicating the need to wear PPE. In addition, there was no PPE available outside the room. On 9/9/24 at 9:10 A.M., an interview was conducted with LN 32. LN 32 stated she wore PPE because Resident 211 had a foley catheter (a device that drains urine from the bladder into a collection bag) and needed the bag to be emptied. LN 32 stated she did not want the urine to splash on her scrubs. On 9/11/24 at 3:03 P.M., an interview was conducted with the Infection Prevention Nurse (IPN). The IPN stated all residents with foley catheters were placed on EBP .to prevent the transmission of multi-drug resistant organisms (MDROs) . The IPN stated Resident 211 should have been placed on EBP immediately upon admission to the facility because .those residents [with indwelling foley catheters] are at higher risk of acquiring MDROs . On 9/12/24 at 9:51 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated having an indwelling catheter placed Resident 211 at risk for infection. The DON further stated .(Resident 211) should have been placed on EBP right away to protect (Resident 211) and others from infection . A review of the facility's policy titled Enhanced Barrier Precautions, revised 6/28/24, indicated, .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .EBPs remain in place for the duration of the resident's stay or until .discontinuation of the indwelling medical device that places them at increased risk .