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	01/15/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a written notice of bed hold rights for one of two residents (Resident 26) reviewed for hospitalization. This failure had the potential for the resident and/or the resident's representative not to have information regarding bed hold rights.Findings: Resident 26 was re-admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's admission Record. During an observation on 1/12/26 at 8:34 A.M., Resident 26 was in bed with his eyes closed. Resident 26 was observed with a tracheostomy (an opening on the neck with a tube to help with breathing) and a feeding tube (tube placed in the stomach). During a review of Resident 26's Minimum Data Set (MDS-a clinical assessment tool) dated 11/18/25, the MDS section C1000 indicated Resident 26's cognitive skills for daily decision making was severely impaired. A review of Resident 26's electronic medical record was conducted. A document titled, SBAR (is a structured, four-step communication tool - Situation, Background, Assessment, Recommendation, used by staff to efficiently report changes in a resident's condition to physicians or nurses) & INITIAL COC [change of condition]/ALERT CHARTING & SKILLED DOCUMENTATION indicated, Resident 26 had fever and abnormal vital signs on 11/18/25. The document further indicated Resident 26's physician ordered to transfer Resident 26 to the emergency room. The document did not indicate if Resident 26's responsible party was provided with a written notice of bed hold rights. An interview on 1/14/26 at 9:43 A.M. was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 26 was transferred to the hospital on [DATE] for a change in condition. LN 2 stated the notice of transfer and discharge was sent to the family by social services. LN 2 stated she was unsure if bed hold was sent to the family. An interview on 1/14/26 at 10:52 A.M. was conducted with the social service assistant (SSA). The SSA stated the nursing staff notified responsible parties regarding bed hold, but did not know who sent the form to them. A follow up interview on 1/14/26 at 11:17 A.M. with the SSA was conducted. The SSA stated a written notice of bed hold was not mailed or sent to residents' responsible parties. An interview was conducted on 1/15/26 at 1:10 P.M., with the Director of Nursing (DON). The DON stated if a resident was transferred to the hospital, a bed hold must be offered, and a written copy should be provided to confirm notification of bed hold rights. A review of the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, dated March 2017 was conducted. The P&P indicated, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The P&P did not provide guidance regarding who was responsible for sending a written bed hold rights to the resident or responsible party when a resident was transferred to the hospital.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a significant change Minimum Data Set (MDS- clinical assessment tool) assessment for one of 24 sampled residents (Resident 115).This failure had the potential to cause the resident to not receive appropriate care.Findings: Per the facility's admission record, Resident 115 was admitted on [DATE] with a diagnosis of other encephalopathy (a brain disease that can cause confusion, memory loss, and coma [a prolonged state of deep unconsciousness]).During a record review of Resident 115's electronic medical record (EMR), the record indicated Resident 115 was admitted to hospice (is specialized, comfort-focused care for residents with a terminal illness (typically six months or less to live) who reside in a nursing home) with a diagnosis of late effect of Cerebral Vascular Accident (CVA-stroke, loss of blood flow to a part of the brain) on 5/20/25. During a record review of Resident 115's paper medical record, the record indicated Resident 115 was discharged from hospice on 11/2/25 for extended prognosis.During a review of Resident 115's MDS assessment dated [DATE], Section O, Special treatment, Procedures, and Programs, the assessment indicated that Resident 115 was receiving hospice services while a resident resided at the facility. During an interview on 1/14/25 at 9:25 A.M. with the MDS nurse (MDSN), the MDSN stated the MDS assessment was used to establish care plans and reimbursement rates. The MDSN further stated that an MDS assessment should have been completed when Resident 115 was discharged from hospice services. The MDSN further stated there should have been a change in condition assessment, the resident could miss care because we thought hospice was coming.During an interview on 1/14/25 at 9:45 A.M. with the Director of Nursing (DON), the DON stated the MDS was the picture of the resident, and that it impacts payment and the resident's plan of care. The DON stated CMS and insurance would think he was still on hospice; the MDSN should have checked No.During a review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 indicated, The SCSA [Significant Change in Status Assessment] is a comprehensive assessment .for either a major improvement or decline . The document further indicates .The nursing home is required to complete an SCSA when the resident comes off the hospice benefit .

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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** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- a standard assessment to facilitate residents' care) related to hospice (medical care for residents expected to live six months or less) services were coded accurately for one of 24 sampled residents (Resident 9). This failure could affect the residents' plan of care.Findings: Resident 9 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and hemiplegia (paralysis affecting one side of the body) per the admission Record. A review of Resident 9's clinical record was conducted on 1/12/26. Per the MDS assessment, dated 11/23/25, Section O: Special Treatments, Procedure, and Programs, indicated Resident 9 was under hospice care and services. Per the Physician's Order dated 6/25/25, Resident 9 was under hospice care and services. A further review of Resident 9's clinical record revealed no documented evidence in the Interdisciplinary Team (IDT- a group of healthcare professionals working together to create a person-centered care plan) notes or progress notes indicating that Resident 9 revoked hospice care and services. On 1/13/26 at 4:00 P.M., a joint interview and record review was conducted with Licensed Nurse (LN) 6. LN 6 stated Resident 9 was discharged from hospice two months prior because the resident requested more aggressive treatment. On 1/13/26 at 4:25 P.M., the Director of Nursing (DON) stated that Resident 9 revoked hospice on 11/13/25. The DON further stated there was no physician order documenting the physician's awareness of the revocation. On 1/14/26 at 3:15 P.M., an interview was conducted with the Minimum Data Set Nurse (MDSN). The MDSN acknowledged she was aware that Resident 9 revoked hospice care and services on 11/13/25 but made a coding error. The MDSN stated she completed the MDS assessment on 11/23/25 and incorrectly coded Resident 9 as under hospice care and services. The MDSN acknowledged that accurate MDS coding was essential to reflect the resident's current health status and ensure an appropriate plan of care. On 1/16/26 at 1:33 P.M., the DON stated the MDS should have been coded accurately. Per the Resident Assessment Instrument (RAI- instructions for MDS completion), dated 10/1/25, indicated .nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow level 2 (evaluation and determination) screening process of the PASARR (Pre-admission Screening and Resident Review, a federally required document to ensure residents are appropriately placed and/or for services) for two of two residents (Resident 5 and 114) reviewed for PASARR. This failure had the potential for Residents 5 and 114, not to receive the care and necessary services in the most appropriate setting. Findings: 1. A review of the clinical record for Resident 5 was conducted. The admission record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia (severe mental health disorder involving distrust and suspicion of other people), and depression. A review of Resident 5's PASARR 1 dated 12/18/25 was conducted. PASARR 1 indicated Resident 5 was positive with Level 1 indicating Level 2 should have been submitted for evaluation and proper placement of Resident 5. An interview with the Minimum Data Set Nurse (MDSN, nurse responsible for conducting an assessment tool) was conducted on 1/13/26 at 3:12 P.M. The MDSN stated she did not see PASARR Level 2 being conducted for Resident 5. The MDSN stated she did not know what happened and that she should have followed up to make sure Resident 5 was getting the right services at the facility. An interview with the Director of Nursing (DON) was conducted on 1/15/26 at 2:03 P.M. The DON stated Resident 5's PASARR Level 2 should have been followed up to ensure proper placement of Resident 5 to meet her care needs. A review of the facility's policy titled admission Criteria, revised 3/2019, indicated, Our facility admits only residents whose medical and nursing care needs can be met .9. All new admission and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level 2 (evaluation and determination) screening process. 2. A review of Resident 114's clinical record was conducted. The admission record indicated that Resident 114 was re-admitted to the facility on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). A review of Resident 114's PASARR 1 dated 5/21/24 was conducted. PASARR 1 indicated Resident 114 was positive with Level 1 indicating Level 2 should have been submitted for evaluation and proper placement of Resident 114. An interview with the MDSN was conducted on 1/13/26 at 3:12 P.M. The MDSN stated she did not see PASARR Level 2 being conducted for Resident 114. The MDSN stated Resident 114's PASARR level 1 indicated a level 2 was required for Resident 114. The MDSN stated she should have followed up to make sure Resident 114 was getting the right services at the facility. An interview with the Director of Nursing (DON) was conducted on 1/15/26 at 2:03 P.M. The DON stated Resident 114's PASARR Level 2 should have been followed up to ensure proper placement of Resident 114 to meet her care needs. A review of the facility's policy titled admission Criteria, revised 3/2019, indicated, Our facility admits only residents whose medical and nursing care needs can be met .9. All new admission and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level 2 (evaluation and determination) screening process.

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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** Based on observation, interview, and record review, the facility did not develop patient centered care plans for two of six residents (Resident 1 and 6) reviewed for care plans. 1. Resident 1 had no teeth. 2. Resident 6 had a GT (GT-a tube inserted into the stomach for nutrition) dressing with discharge. These failures had the potential to negatively affect the residents' (1, 6) needs, affecting their dignity, comfort, safety, and well-being. Findings: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's admission Record. The admission Record also indicated Resident 1's daughter was the responsible party (RP). An observation of Resident 1 was conducted on 1/12/26 at 9:06 A.M. Resident 1 was in bed with a tracheostomy (an opening on the neck with a tube to help with breathing) and feeding tube (tube in the stomach). Resident 1 had a beard and long moustache which covered half of Resident 1's mouth. Resident 1 attempted to speak but had no voice. A phone interview on 1/13/26 at 9:49 A.M. was conducted with Resident 1's daughter/RP. The RP stated she notified facility staff during care conference that Resident 1 needed dentures but had not heard back from the facility. The RP stated Resident 1 wavered on trimming moustache and shaving because it covered Resident 1's mouth. During a follow up observation and interview on 1/14/26 at 9:39 A.M. with Resident 1, Resident 1 whispered he would like to keep his moustache. Resident 1 further whispered he had no teeth and would like dentures. A review of Resident 1's care plans was conducted. Care plans for Resident 1 did not indicate Resident 1's oral status. During an interview on 1/15/26 at 7:55 A.M. with the Minimum Data Set Nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents), the MDSN stated care plans should address residents' oral status because they affect the overall plan of care for residents. An interview and concurrent record review on 1/15/26 at 8:12 A.M. was conducted with the Social Service Director (SSD). The SSD reviewed the social service assessments for Resident 1. The SSD stated the social service assessments dated 7/24/25 and 10/23/25 indicated, Resident 1 has own teeth. The SSD stated if a resident had no teeth, she would refer to the dentist if the resident or responsible party requested dentures. The SSD further stated residents with tube feeding should also have dentures if requested, for their self-esteem. During an interview on 1/15/26 at 8:22 A.M. with Licensed Nurse (LN) 3, LN 3 stated she checked Resident 1's mouth and confirmed Resident 1 did not have teeth. An interview and concurrent record review on 1/15/26 at 8:26 A.M. with LN 4 was conducted. LN 4 stated there was no care plan for Resident 1 to address Resident 1 not having teeth. LN 4 stated it was important to care plan for resident's risk for infection and low intake due to not having teeth. During an interview on 1/15/26 at 1:10 P.M. with the Director of Nursing (DON), the DON stated having dentures were part of resident's body image which allowed the resident to eat and chew, and prevent weight loss. The DON stated it was important to have a care plan because it was the resident's plan of care. 2. Resident 6 was admitted to the facility on [DATE] with diagnoses including other specified muscular dystrophies (MD- a genetic disease-causing progressive muscle weakness and loss) and presence of gastrostomy (GT-a tube inserted into the stomach for nutrition) according to the facility's admission Record. An interview and concurrent observation of Resident 6 was conducted on 1/13/26 at 3:28 P.M. with Licensed Nurse (LN) 1. Resident 6 was in bed with tube feeding infusing. LN 1 removed Resident 6's dressing from the GT site. The dressing had a small amount of grayish/tan discharge. The GT site's surrounding was pink in color. LN 1 stated the discharge could be pus. A follow up interview and concurrent observation of Resident 6 was conducted on 1/14/26 at 3:33 P.M. with Treatment Nurse (TN) 1. TN 1 removed the dressing from Resident 6's GT site. The dressing had grayish/green discharge and a small amount of blood on the opening of the split of the dressing. The GT site was observed with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reddened surroundings. An interview and joint record review was conducted on 1/15/26 at 8:32 A.M. with LN 4. LN 4 reviewed the care plans for Resident 6. LN 4 stated there was no care plan to address the GT discharge. LN 4 stated the care plan was only developed yesterday, 1/14/26. LN 4 stated there should have been a care plan prior to 1/14/26 because it was a change in condition and the GT site required monitoring for signs of infection. During an interview on 1/15/26 at 1:10 P.M. with the Director of Nursing (DON), the DON stated it was important to have a care plan because it was the resident's plan of care. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated December 2016 was conducted. The P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The care planning process will.Facilitate resident and/or representative involvement.

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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** Based on the interview and record review, the facility failed to ensure the Interdisciplinary Team (IDT- a group of healthcare professionals working together to create a person-centered care plan) meeting was documented for one of 24 sampled residents (Resident 9), when Resident 9 decided to revoke hospice service (medical care for residents expected to live six months or less). This failure had the potential to affect the revision of the care plan to reflect Resident 9's goals and preferences.Findings: Resident 9 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and hemiplegia (paralysis affecting one side of the body) per the admission Record. On 1/12/26 at 9:10 A.M., Resident 9 was observed in bed with eyes closed and wearing a hospital gown. A review of Resident 9's clinical record was conducted on 1/12/26. Per the MDS assessment dated [DATE], Section O: Special Treatments, Procedures, and Programs indicated Resident 9 was under hospice care and services. Per the Physician's Order dated 6/25/25, Resident 9 was under hospice (a specialized, interdisciplinary care model for individuals with terminal illnesses (typically with life expectancy of six months or less) care and services. Further review of Resident 9's clinical record revealed no documented evidence in the Interdisciplinary Team meeting notes or progress notes to indicate Resident 9 revoked hospice care and services. In addition, there was no physician order to indicate hospice services were discontinued. On 1/13/26 at 4:00 P.M., a joint interview and record review was conducted with Licensed Nurse (LN) 6. LN 6 stated Resident 9 was discharged from hospice care two months prior because the resident requested more aggressive treatment. On 1/13/26 at 4:25 P.M., the Director of Nursing (DON) stated Resident 9 revoked hospice on 11/13/25. The DON further stated that there was no physician order documenting the physician's awareness of the revocation, and there should have been. On 1/14/26 at 10:00 A.M., an interview was conducted with LN 6. LN 6 stated she recalled there was an IDT meeting about Resident 9 no longer receiving hospice, but she could not explain why it was not documented. LN 6 stated that social services was responsible for documenting the meeting. On 1/14/26 at 4:15 P.M., a joint interview and record review was conducted with the Social Service Director (SSD). The SSD stated there was no formal IDT meeting when Resident 9 revoked hospice care and services. The SSD further stated there should have been documented evidence of the IDT meeting to assess and update the care plan and to ensure that the care was aligned with Resident 9's wishes. On 1/15/26 at 1:33 P.M., the DON stated she received a call from family members and explained the hospice revocation process. The DON stated on 11/6/25, there was an IDT (is a collaborative group of healthcare professionals, staff, and family members responsible for developing and implementing a comprehensive, person-centered care plan for residents) meeting that she facilitated about hospice revocation, and on 11/13/25, Resident 9 revoked hospice care and services. The DON further stated the IDT meeting should have been documented in Resident 9's clinical record to show collaboration amongst the IDT. Per the facility's policy and procedure dated 3/2022, titled Care Planning - Interdisciplinary Team, The interdisciplinary team is responsible for the development of resident care plans. Per the facility's policy and procedure dated 12/2022, titled Care Plans, Comprehensive Person-Centered, .8. The Comprehensive, person-centered care plan will: Reflect the resident's expressed wishes regarding care and treatment goals

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six residents (128), who was unable to carry out activities of daily living (ADLs - self- care activities such as grooming, bathing, and toileting), received assistance with nail care [cleaning, trimming and/or filing of nails]) and shaving. As a result of this deficient practice, Resident 128 was unshaven with debris under Resident 128's fingernails which had the potential to affect Resident 128's comfort and wellbeing.Findings: Resident 128 was admitted to the facility on [DATE] with diagnoses including respiratory failure (a condition when lungs cannot get enough oxygen in the blood) and need for assistance with personal care according to the facility's admission Record. During an observation and interview of Resident 128 was conducted on 1/12/26 at 8:49 A.M. Resident 128 was eating breakfast with black debris under fingernails and unshaven. Resident 128 had a tracheostomy (an opening on the neck with a tube to help with breathing) and nodded, indicating he wanted to be shaved. During a follow-up observation on 1/13/26 at 3:22 P.M. Resident 128 was sitting up in bed, shaved with a moustache. Resident 128 smiled and touched his head and face. Resident 128's fingernails were short but had black debris underneath. A review of Resident 128's electronic medical record (EMR) was conducted. The Minimum Data Set (MDS-a clinical assessment tool) dated 1/13/26, section C0500 indicated, Resident 128's Brief Interview for Mental Status (BIMS- evaluates cognition, the ability to remember and think clearly) score was 15, which indicated intact cognition. Section GG0130I indicated Resident 128 required substantial/maximal assistance with personal hygiene. During an interview on 1/14/26 at 10:14 A.M. with Licensed Nurse (LN) 2, LN 2 stated nail care was provided by the assigned CNA (certified nursing assistant) on Saturdays. LN 2 stated the treatment nurse was responsible for checking. LN 2 stated shaving of residents were provided during showers. An interview and joint observation was conducted on 1/15/26 at 8:57 A.M. with Treatment Nurse (TN) 2. TN 2 stated nail care was provided on Tuesdays and Thursdays, and as needed. TN 2 stated shaving of residents was provided as needed. Resident 128 was in bed and showed his fingernails to TN 2. TN 2 stated Resident 128's fingernails were dirty and should be cleaned. An interview with the Director of Nursing (DON) was conducted on 1/15/26 at 1:10 P.M. The DON stated shaving and nail care were part of personal care and skin care. The DON stated personal care was important for the resident's body image, dignity, and comfort. The DON further stated shaving should be done daily if needed. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living [ADL], Supporting, dated March 2023 was reviewed. The P&P indicated, Resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living [ADLs]. 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.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide social service assistance for one of six residents (Resident 1) reviewed for medically-related social services when:1. A dental referral was not provided, 2. A hearing consultation was missed, 3. The social services assessments were inaccurate. These failures had the potential to delay care and services for the resident which could affect the resident's health and wellbeing, and quality of life. Findings: 1.Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's admission Record. The admission Record also indicated Resident 1's daughter was the responsible party. An observation of Resident 1 was conducted on 1/12/26 at 9:06 A.M. Resident 1 was in bed with a tracheostomy (an opening on the neck with a tube to help with breathing) and feeding tube (tube in the stomach). Resident 1 was observed with a beard and long moustache which covered half of Resident 1's mouth. Resident 1 attempted to speak but had no voice. A phone interview on 1/13/26 at 9:49 A.M. was conducted with Resident 1's daughter. Resident 1's daughter stated she notified facility staff during care conference that Resident 1 needed dentures but had not heard back from the facility. Resident 1's daughter stated Resident 1 wavered on trimming and shaving the moustache because it covered Resident 1's mouth. An interview on 1/14/26 at 9:08 A.M. was conducted with the Social Service Director (SSD) and Social Service Assistant (SSA). The SSD stated dental visits were on an as-needed basis. The SSD stated Resident 1 was not in the log for dental referral. During a follow up observation and interview on 1/14/26 at 9:39 A.M. with Resident 1. Resident 1 had no teeth, whispered that he would like to keep his moustache and would like dentures. 2. During an interview on 1/14/26 at 9:08 A.M. with the SSD and the SSA, the SSA stated Resident 1's last care conference was held in October 2025. The SSA stated Resident 1's daughter had requested an eye, nose and throat (ENT) consultation due to Resident 1's difficulty with hearing. The SSA reviewed the referral log. Resident 1's name was not on the list for ENT. The SSA stated she missed checking the log to ensure that Resident 1 was added. The SSD stated it was important for residents to be seen by ancillary services (additional services from providers outside the facility) to have normality and assist the residents' quality of life. 3. An interview and concurrent record review was conducted with the Social Service Director (SSD) on 1/15/26 at 8:12 A.M. The SSD stated residents' oral status was checked upon admission and quarterly and there was a standing physician's order for dental and hearing consultations upon admission to the facility. The SSD reviewed the social service assessments for Resident 1. The SSD stated the social service assessments dated 7/24/25 and 10/23/25 indicated Resident 1 has own teeth. The SSD stated if a resident had no teeth, she would refer to the dentist, provided the resident or responsible party requested dentures. The SSD further stated residents with tube feeding should also have dentures if requested for their self-esteem. During an interview on 1/15/26 at 8:22 A.M. with Licensed Nurse (LN) 3, LN 3 stated she checked Resident 1's mouth and confirmed Resident 1 did not have teeth. An interview on 1/15/26 at 1:10 P.M. was conducted with the Director of Nursing (DON). The DON stated she confirmed that Resident 1 did not have teeth and the social services assessments were inaccurate. The DON stated resident referrals should be followed because it was part of the facility's services provided to the residents. The DON stated it was important to provide a homelike environment such as having consultations from outside services. The DON further stated dental assessments should be accurate to ensure a dental referral would be made if needed. During a review of the facility's policy and procedure (P&P) titled, Dental Services, dated December 2016, the P&P indicated, Social services representative will assist residents with appointments, transportation arrangements, and reimbursement for dental services under the state plan, if eligible. A review of the (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	01/15/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's P&P titled, Referral, Social Services, dated December 2008 was conducted. The P&P indicated, Social services personnel shall coordinate most resident referrals with outside agencies.Social services will coordinate with nursing staff or other pertinent disciplines to arrange for services that had been ordered by the physician.Social services will document the referral in the resident's medical record. During a review of the facility' P&P titled, Dental Examination/Assessment, dated December 2013, the P&P indicated, Each resident shall undergo a dental assessment prior to or within ninety (90) days of admission. Resident shall be offered dental services as needed.Dental examinations will be made by the resident's personal dentist or by the facility's Consultant Dentist. The policy did not provide guidance on how facility staff should conduct a dental assessment to determine the need for a referral.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an open food item was labeled with an open date and stored properly in the reach-in refrigerator in the kitchen. This failure had the potential to cause food borne illness.Findings: On 1/12/26 at 7:49 A.M., a joint observation of the kitchen area was conducted with the Dietary Manager (DM). Inside the reach-in refrigerator was a torn-opened, used, unsealed crumpled plastic wrapper containing butter. The DM disposed of the butter and stated the butter should have been labeled, dated, and stored properly for the safety of the residents. Per the facility's policy and procedure, dated 2023, titled Labeling and Dating of Foods, indicated .Newly opened food items will be closed and labeled with an open date and used by the date that follows the various storage guidelines .

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure infection control procedures were followed when: 1. Licensed Nurse (LN) 11 did not wear a gown consistently while providing care to Resident 86 who was on enhanced barrier precautions (EBP - involves gown and glove use during high-contact resident care activities for residents [example: residents with medical devices]), during medication (med) pass. 2. A certified nursing assistant (CNA) failed to properly use personal protective equipment (PPE - equipment such as gown and gloves used to protect staff and residents from potentially infectious diseases) while providing care for one of 24 sampled residents (Resident 94). These failures had the potential for cross contamination and spread of infection. Findings: 1. A review of Resident 86's admission Record indicated Resident 86 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (ESRD-irreversible kidney failure). On 1/15/26 at 7:50 A.M., an observation and interview were conducted with Licensed Nurse (LN) 11. LN 11 prepared the medications for Resident 86. There was an EBP sign attached to Resident 86's door. LN 11 stated she will check Resident 86's vital signs. LN 11 checked Resident 86's vital signs without donning a gown. LN 11 went back to the medication cart, looked at the EBP sign at Resident 86's door, and stated, I should have worn PPE. I was in close contact with the resident because she was on EBP. On 1/15/25 at 8:32 A.M., another observation and interview of LN 11 was conducted. LN 11 went back to Resident 86's room and listened to Resident 86's lung sounds without putting on a gown. LN 11 spent 14 minutes with Resident 86 while conducting and assisting Resident 86 on an incentive spirometer (a way to do breathing exercises). LN 11's clothing was in close contact with Resident 86's clothes. LN 11 stated, I should have worn a gown, and I forgot again when I assessed her. On 1/15/26 at 2:02 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the staff to follow the procedures on EBP consistently to prevent spread of infection especially if in close contact with the resident. A review of the facility's policy titled, Enhanced Barrier Precautions revised August 2022, indicated, .1. Enhanced barrier precautions (EBP) are used as an infection prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDRO- bacteria resistant to multiple medications) to residents.6. EBPs remain in place for the duration of the resident's stay or.discontinuing of the indwelling medical device that places them at increased risk. 2. Resident 94 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder (a condition that causes loss of control, holding, or releasing urine) per the facility's admission Record. On 1/12/26 at 8:30 A.M., Resident 94 had EBP(enhanced barrier precautions [EBP] - involves gown and glove use during high-contact resident care activities for residents [example: residents with medical devices) signage posted on the door. Resident 94 was in bed and noted an indwelling catheter (a flexible tube that drains urine) attached to the catheter bag that was hanging on the side of the (continued on next page)

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	055508	A. Building B. Wing	01/15/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. On 1/12/26 at 9:22 A.M., an interview was conducted with Resident 94. Resident 94 stated he had a suprapubic catheter (urine tube inserted in the stomach) and was on EBP because of an infection he had in the past. On 1/14/26 at 8:47 A.M., Resident 94's door was observed fully opened, and the privacy curtain was drawn up to the edge of the bed. The staff was wearing gloves without a gown while assisting Resident 94 to dress, reposition, and move the indwelling catheter to the side of the bed. On 1/14/26 at 9 A.M., an interview was conducted with the staff after providing care to Resident 94 who introduced as certified nursing assistant (CNA 2). CNA 2 stated she emptied the indwelling catheter and provided a bed bath to Resident 94 without proper PPE (equipment such as gown and gloves used to protect staff and residents from potentially infectious diseases). CNA 2 stated she did not wear the PPE because Resident 94 was in a hurry to get up. CNA 2 stated she should have used the PPE to prevent the spread of infection. On 1/15/26 at 8:30 A.M., an interview was conducted with the Infection Preventionist Nurse (IPN). The IPN stated the staff should wear the PPE (gown and gloves) during high-contact resident care because the PPE served as a barrier to protect themselves and others, and avoid the spread of germs. On 1/15/26 at 8:35 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that staff should follow the EBP protocol to prevent the spread of infection. Per the facility's policy and procedure, dated 8/2022, titled Enhanced Barrier Precaution, Enhanced barrier precaution (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDRO-bacteria resistant to multiple medications) to residents.