| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055761 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Encinitas Nursing and Rehabilitation Center | 900 Santa Fe Drive<br>Encinitas, CA 92024 |

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) |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) had a written plan of care revised after a pressure injury (damage to the skin and underlying structures caused by unrelieved pressure) worsened from a stage 2 (a partial-thickness, or shallow, loss of skin appearing as a shallow open ulcer or a clear fluid filled blister) to unstageable (a full-thickness ulcer where the depth cannot be determined because it is covered with dead tissue)<br><br>As a result of this deficient practice, there was the potential for Resident 1 to experience further deterioration of the wound.<br><br>Findings:<br><br>A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included left femur fracture (a broken thigh bone), need for assistance with personal care, and cognitive communication deficit (impaired thought processes such as memory and reasoning) and discharged home on 4/29/25.<br><br>A review of Resident 1's Skin and Wound Evaluation, dated 4/24/25, indicated Resident 1 had a stage 2 pressure injury to the right heel which worsened to unstageable (a wound with full-thickness skin and tissue loss).<br><br>A review of Resident 1's care plan dated 4/19/24 indicated, [Resident 1] was noted to have right heel blister. The care plan had not been revised when the wound became unstageable.<br><br>On 7/7/25, a joint interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 1's care plan should have been revised when her wound worsened from a stage 2 to unstageable pressure injury. The ADON stated it was important to update the care plan because, .it allows the resident to have the appropriate care.<br><br>A review of the facility's policy titled Care Plan, Episodic dated 8/2014 indicated, It is the policy of this facility to develop an episodic/short term care plan for acute temporary changes and/or condition .to establish guidance to all disciplines on meeting the individual needs of the resident . |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and services to heal pressure injuries (damage to the skin and underlying structures caused by unrelieved pressure) for two of three sampled residents (Resident 1 and Resident 2) when:<br><br>1. Wound care orders for a pressure injury that worsened from a stage 2 pressure injury (a partial-thickness loss of skin appearing as a shallow open ulcer or a clear fluid filled blister) to an unstageable pressure injury (a full-thickness ulcer where the depth cannot be determined because it is covered with dead tissue) were not implemented, an Interdisciplinary Team (IDT-a group of individuals with different areas of expertise) Meeting was not conducted to address Resident 1's pressure injury and the attending physician was not notified of the worsening of the pressure injury for Resident 1<br><br>and<br><br>2. A low air loss mattress for one resident with a pressure injury (Resident 2) was not correctly set to the resident's weight.<br><br>Findings:<br><br>1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included left femur fracture (a broken thigh bone), need for assistance with personal care, and cognitive communication deficit and discharged home on 4/29/25.<br><br>During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk dated 3/5/25, the assessment indicated Resident 1 was at risk for developing a pressure injury.<br><br>During a review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 3/10/25, Resident 1 had a BIMS (Brief Interview of Mental Status- a tool to measure cognition) of 4, which indicated severe cognitive impairment. The MDS indicated Resident 1 did not have any pressure injuries when admitted to the facility.<br><br>During a record review on 6/25/25, the Change in Condition dated 4/19/25 indicated Resident 1 was noted with a intact clear fluid filled blister (a stage 2 pressure injury) to the right heel. The record indicated, Things that make the condition or symptoms unchanged .not floating heels or positioning .Other relevant information: resident with fragile skin .<br><br>During a record review on 6/25/25, the MD/NP/PA note dated 4/24/25 at 9:15 A.M. indicated WOUND 1 (Date assessed 4/17/25) LOCATION/ETIOOGY: R heel/unstageable .TISSUE BED: 1.2 x 0.9 x UTD cm3 . Slough [dead tissue] 100% .DRESSING USED: medihoney [a dressing used to treat open wounds] and foam dressing .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review on 6/25/25, the Treatment Administration Record (TAR) indicated, apply skin prep to blister to right heel .). The TAR indicated skin prep (a barrier wipe designed to protect intact skin) was applied to Resident 1's right heel wound on 4/20/25, 4/22/25, 4/23/25, 4/24/25, 4/26/25, 4/27/25, and 4/28/25. The TAR did not indicate that medihoney was used to treat Resident 1's right heel wound.<br><br>On 7/2/25 at 9:18 A.M., a telephone interview was conducted with the Wound Nurse Practitioner (WNP) 1. WNP 1 stated a clear fluid filled blister to the heel was a stage 2 pressure injury (a partial thickness, or superficial, wound). WNP 1 stated when he assessed Resident 1's right heel wound on 4/17/25, the blister had opened and the wound was covered with slough, which meant the wound had worsened to unstageable. Per WNP 1, .we don't know the depth [of an unstageable pressure injury], but it would be a stage 3 or 4 [full thickness, or deeper, wounds] . WNP 1 stated his recommendation was to change the wound care order to cleanse the wound, apply medihoney then apply a foam dressing. WNP 1 stated applying skin prep to an open wound, .wouldn't make it better or worse .but applying the medihoney probably would have been better for the wound .<br><br>During a joint interview and record review with the Assistant Director of Nursing (ADON) on 7/7/25 at 9:30 A. M., the ADON stated an IDT meeting was not done for Resident 1's wounds. The ADON stated, .the ultimate goal of an IDT is to prevent further wounds from happening, and to figure out what to do for the wounds to get better . The ADON stated there was no treatment order implemented for Resident 1's unstageable pressure injury to the right heel. The ADON stated it was important to follow up with wound care recommendations from WNP 1. She stated, .[the treatment order] should have been changed to medihoney . The ADON further stated, .I checked several places [in Resident 1's medical records], there was no notification to the doctor . The ADON stated Resident 1's attending physician should have been notified that Resident 1's wound had worsened from a stage 2 to an unstageable pressure injury.<br><br>During a review of the facility policy titled Pressure Injury Prevention and Management revised 12/3/24, the policy indicated, The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries .The attending physician will be notified of: The presence of a new pressure injury upon identification .the progression towards healing, or lack of healing, of any pressure injuries weekly .Any complications .<br><br>2. During a record review on 6/25/25, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy and Moyamoya disease (a rare disease that affects the brain's blood vessels).<br><br>A review of the Minimum Data Set (MDS-an assessment tool) dated 6/11/25 indicated resident had a BIMS (Brief Interview of Mental Status-a cognition tool) of 00, which indicated resident had severe cognitive impairment. The MDS indicated Resident 2 required either Substantial/maximal assistance or was dependent on all Activities of Daily Living (ADL's-personal care, eating, dressing, hygiene). The MDS indicated Resident 2 had a stage 3 (full thickness) pressure injury and had a pressure reducing device for the bed. During a record review on 6/25/25, the Physician's Order dated 6/8/25 indicated, Low Air loss Mattress for Wound Management.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/25/25 at 10:06 A.M., an observation was conducted Resident 2's room. Resident 2 was laying in bed, on an low air loss mattress. The mattress was connected to a control unit, which indicated the mattress was set to a firmness for a resident who weighed 250 pounds.<br><br>On 6/25/25 at 10:20 A.M., a joint interview and record review was conducted with Treatment Nurse (TN) 1. TN 1 stated LAL mattresses were used to help treat and heal pressure injuries. LN 1 stated it was important for the LAL mattress to be set appropriately based on Resident 2's weight. TN 1 stated, .[Resident 2] definitely doesn't weigh 250 pounds . and that the mattress was not set to Resident 2's weight. According to the Weight Summary dated 6/16/25, Resident 2 weighed 91 pounds. TN 1 stated, We have to make sure it isn't too hard, so it is helping to heal the wound . TN 1 stated her expectation was for a low air loss mattress to be set correctly based on Resident 2's weight.<br><br>During a review of the facility's policy titled Pressure Injury Prevention and Management revised 12/3/24 indicated, Evidence-based interventions .will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: . Provide appropriate, pressure-redistributing, support surfaces . The policy did not provide guidance regarding the settings of low air loss mattresses. |