STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055761	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encinitas Nursing and Rehabilitation Center	900 Santa Fe Drive 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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on interview, record review, and facility document review, the facility failed to ensure staff provided appropriate notices of payor source changes to residents when the residents were discharged from Medicare Part A Skilled Services with days of eligibility remaining. This deficient practice affected 2 (Resident #34 and Resident #45) of 3 residents reviewed for beneficiary notification. Findings included: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An untitled and undated document provided by the facility as their policy revealed a section of the document titled, 50 - Advance Beneficiary Notice of Non-coverage (ABN) included, Section 1879 of the Act [Social Security Act] (where the LOL [limitation on liability] provisions are located) requires a healthcare provider or supplier (i.e.[id est, that is] notifier) to notify a beneficiary in advance of furnishing an item or service when s/he believes the items or services will likely be denied by Medicare for any of the reasons specified in the statuary provision in order to shift financial liability to the beneficiary for the denial. The document revealed the section titled 50.6-Completing the ABN, included, If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign or chose an option and may list witness(es) to the refusal on the notice although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/services, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that is not an option. In any case, the notifier should provide a copy of the annotated ABN to the beneficiary, and keep original version of the annotated notice in the patient's file. The document revealed the section titled, 50-8-Effective ABN Delivery included, ABN delivery is considered to be effective when the ABN is: 1. Delivered to a suitable notifier to a capable recipient and comprehended by that recipient. 3. Delivered to the beneficiary in person if possible. 4. Provided far enough in advance of delivering potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options. 6. Signed by the beneficiary. The document revealed the section titled, 50.8.1 - Options for Delivery Other than In-person, included, ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be non-covered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN using another method. Examples include: -Direct telephone contact; -Mail; -Secure fax machine; or -Internet e-mail. All methods of delivery require adherence to all statutory privacy requirements under HIPPA [Health Insurance Portability and Accountability Act]. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery, when delivery is not in-person, the notifier must verify that contact was made in his/her records. In order to consider effective, the beneficiary should not dispute such contact. Telephone contacts should be followed immediately by either a hand-delivered, mailed, emailed, or a faxed notice. The beneficiary should sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient's record. The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the notice should document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself. Further review revealed the document did not include any direction for the Notice of Medicare Non-Coverage (NOMNC). 1. An Admission Record revealed the facility admitted Resident #34 on 09/08/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease without heart failure (onset date 01/25/2025) and stage 3 chronic kidney disease (onset date 01/25/2025). The Admission Record indicated the resident had a responsible party and a health care decision maker. A quarterly Minimum Data Set assessment, with an Assessment Reference Date (ARD) of 01/02/2025, revealed the resident was independent in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). A Census List for Resident #34 revealed that the resident was Transferred In from Hospital on 01/25/2025 and had a Payor Change on 02/02/2025. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), signed by two staff members and dated 02/07/2025, revealed, Medicare does not pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 02/02/25, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. Further review revealed the form did not indicate which care did not meet Medicare coverage requirements. The form revealed a table titled OPTIONS: that directed staff that only one box could be checked, and that staff could not choose a box for the resident. The form revealed Option 1 was checked which indicated, I want the daily skilled care listed above, which includes custodial services and room and board charges. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for paying, but I can appeal to Medicare by following the directions on the MSN. The form revealed that in the blank where the resident or their representative should sign, two staff members signed. Further review revealed the resident, or their representative did not sign the form. Resident #34's Notice of Medicare Non-Coverage form revealed that two staff members signed the form and dated it 01/29/2025. The resident or the resident's representative did not sign the form. During an interview on 04/29/2025 at 1:31 PM, Case Manager (CM) #1 confirmed that it was her signature and the signature of a social services staff member on Resident #34's SNF ABN and NOMNC. She stated that they provided the SNF ABN after the resident was discharged from Part A Skilled Services, the day following. She stated that she was not sure when the forms needed to be provided, and the Social Worker was on maternity leave, so she had been trying to cover. She stated she did not remember if she called Resident #34's family member and did not believe that it was documented anywhere that they had called them since the resident was unable to sign. She stated she would look to see if she could find some documentation to show they had verbal consent from the resident or the resident's family. She stated that she checked the box for Option #1 because she thought that meant they did not want to continue therapy services and did not know it meant the resident wanted to continue to receive services and appeal the decision. During an interview on 04/29/2025 at 1:52 PM, CM #1 verified that she did not have documentation to show she had provided the SNF ABN to Resident #34 or the resident's representative or that they refused to sign. During an interview on 05/01/2025 at 12:01 PM, the Director of Nursing (DON) stated she expected that the staff provide the NOMNC within 72 hours of the resident's discharge from Part A skilled services. The DON stated that the SNF ABNs were a little more difficult as they were only given to residents who were moving to long-term care. The DON stated most residents came into the facility for short-term care then would transition to long-term care. The DON stated she expected staff to provide the notices timely and to document when they were given and if the resident or their responsible party signed or not. During an interview 05/01/2025 at 12:05 PM, the Administrator stated he expected staff to provide the NOMNC and SNF ABN as required and to document in the record if the resident did not or could not sign or if their responsible party was called and was not present to sign. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An Admission Record revealed the facility originally admitted Resident #45 on 07/28/2020 and readmitted the resident on 02/28/2025. According to the Admission Record, the resident had a medical history that included diagnoses of depression, need for assistance with personal care, cognitive communication deficit, spinal stenosis, chronic kidney disease stage 3, chronic pain syndrome, and acute embolism and thrombosis of superficial veins of right upper extremity. The Admission Record revealed the resident was listed as their own responsible party and health care decision maker. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/13/2025, revealed the resident had a Brief Interview of Mental Statue (BIMS) score of 15, which indicated the resident had intact cognition. Resident #45's Census List revealed that the resident was readmitted to the facility on [DATE] and had a Payor Change on 04/13/2025. Resident #45's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) form signed by two staff members and dated 04/12/2025, revealed, Medicare does not pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 04/13/25, you may have to pay out of pocket for this care if you do not have other insurance that may cover those costs. Further review revealed the form did not indicate which care did not meet Medicare coverage requirements. The form revealed a table titled OPTIONS: that directed staff that only one box could be checked, and that staff could not choose a box for the resident. The form revealed Option 1 was checked which indicated, I want the daily skilled care listed above, which includes custodial services and room and board charges. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for paying, but I can appeal to Medicare by following the directions on the MSN. The form revealed that in the blank where the resident or their representative should sign, two staff members signed. Further review revealed the resident, or their representative did not sign the form. During an interview on 04/29/2025 at 1:15 PM, Resident #45 stated they did not know who signed their SNF ABN. During an interview on 04/29/2025 at 1:31 PM, Case Manager (CM) #1 confirmed that it was her signature and the signature of a social services staff member on Resident #45's SNF ABN. She stated that they provided the SNF ABN after the resident was discharged from Part A Skilled Services, the day following. She stated that Resident #45 refused to sign but she did not believe that they documented it anywhere. She stated she was not sure when the forms needed to be provided, and the Social Worker was on maternity leave, so she had been trying to cover. She stated that she checked the box for Option #1 because she thought that meant they did not want to continue therapy services and did not know it meant the resident wanted to continue to receive services and appeal the decision. During an interview on 04/29/2025 at 1:52 PM, CM #1 verified that she did not have documentation to show she had provided the SNF ABN to Resident #45. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 12:01 PM, the Director of Nursing (DON) stated if a resident did not want to sign or if staff needed to call the resident's representative, she expected staff to document in the record when they gave the notifications. The DON stated she expected staff to provide the notices timely and to document when they were given and if the resident or their responsible party signed or not. During an interview on 05/01/2025 at 12:05 PM, the Administrator stated he expected staff to provide the SNF ABN as required and to document in the record if the resident did not or could not sign or if their responsible party was called and was not present to sign.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 49044 Based on interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid (CMS) Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure comprehensive Minimum Data Set (MDS) assessments were signed as complete within 14 days of the Assessment Reference Dates (ARDs) for 2 (Resident #106 and Resident #28) of 17 residents reviewed for resident assessments. Findings included: A facility policy titled, Resident Assessment - RAI [Resident Assessment Instrument], dated 09/18/2024, revealed, This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS. The policy indicated, 1. The current version of the RAI (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with the instructions found in the RAI Manual. The CMS Long-Term Care RAI 3.0 User's Manual, Version 1.19.1, dated 10/2024, revealed Chapter 2: Assessments for the Resident Assessment Instrument (RAI), specified, 02. Annual Assessment (A0310A=3) The annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA (significant change in status assessment) or an SCPA (significant correction a prior comprehensive assessment) has been completed since the most recent comprehensive assessment was completed. The manual specified, -The ARD [Assessment Refence Date] (item A2300) must be set within 366 days after the ARD of the previous OBRA [Omnibus Budget Reconciliation Act] comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA [significant correction to prior quarterly assessment] (ARD of previous OBRA Quarterly assessment + 92 calendar days). -The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). 1. An Admission Record revealed the facility admitted Resident #106 on 05/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease; adult failure to thrive; dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety; and disorientation. Resident #106's MDS history included a quarterly MDS and a modification of a quarterly MDS, both with an ARD of 01/06/2025, followed by an annual MDS, with an ARD of 03/26/2025. The resident's MDS history indicated the annual MDS with an ARD of 03/26/2025 was still In Progress. Resident #106's annual MDS, with an ARD of 03/26/2025, revealed that not all sections were complete; only Sections C, D, K, and parts of Section J were complete. Section Z0500 revealed the assessment had not yet been signed to indicate the assessment was complete. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 10:42 AM with the Director of Nursing (DON), the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. MDS Assistant #4 further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. The DON stated Resident #106's annual MDS, with an ARD of 03/26/2025, was not completed timely, because it was not yet completed. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 52274 2. An Admission Record revealed the facility admitted Resident #28 on 09/03/2018. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease without dyskinesia (movement disorder characterized by involuntary movements), restless leg syndrome, and schizoaffective disorder. Resident #28's annual MDS, with an ARD of 02/27/2025, revealed Section Z0500 reflected that the Director of Nursing (DON) signed the assessment as complete on 04/25/2025, more than 14 days from the ARD. During an interview on 05/01/2025 at 10:42 AM with the DON, the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. MDS Assistant #4 further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 52275 Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed at least once every three months and were signed as complete within 14 days of the Assessment Reference Dates (ARDs) for 7 (Residents #41, #47, #100, #26, #31, #110, and #27) of 17 residents reviewed for resident assessments. Findings included: The CMS Long-Term Care RAI 3.0 User's Manual, Version 1.19.1, dated 10/2024, revealed Chapter 2: Assessments for the Resident Assessment Instrument (RAI), specified, 05. Quarterly Assessment (A0310A=2) The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment that must be completed at least every 92 days following the previous OBRA assessment of any type. The manual specified, -The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA [significant change in status assessment], SCPA [significant correction to a prior comprehensive assessment], SCQA [significant correction to a prior quarterly assessment], or Annual assessment + 92 calendar days). -The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). 1. An Admission Record revealed the facility admitted Resident #41 on 01/19/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of sequelae of cerebral infarction. Resident #41's MDS history included an annual MDS with an ARD of 12/12/2024, followed by a quarterly MDS with an ARD of 03/03/2025. Resident #41's quarterly MDS, with an ARD of 03/03/2025, revealed Sections A, GG, H, P, and S were not completed until 03/27/2025; parts of Section B and Section E were not completed until 04/22/2025 and 04/27/2025; Section Q was not completed until 04/22/2025; and Section L, Section M, and parts of Section J were not completed until 04/27/2024. Section Z0500 revealed the Director of Nursing (DON) signed the assessment as complete on 04/28/2025, more than 14 days after the assessment ARD. During an interview on 05/01/2025 at 10:42 AM with the DON, the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. MDS Assistant #4 further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 2. An Admission Record revealed the facility admitted Resident #47 on 12/05/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of congestive heart failure. Resident #47's MDS history included a quarterly MDS with an ARD of 11/28/2024, followed by a quarterly MDS with an ARD of 02/17/2025. Resident #47's quarterly MDS, with an ARD of 02/17/2025, revealed Sections A, B, E, H, I, L, O, P, S, Q, and parts of Section M were not completed until 04/16/2025; Section N and parts of Section J were not completed until 04/18/2025; and parts of Section M were not completed until 04/23/2025. Section Z0500 revealed the Director of Nursing (DON) signed the assessment as complete on 04/24/2025, more than 14 days after the ARD. During an interview on 05/01/2025 at 10:42 AM with the DON, the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. She further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 3. An Admission Record revealed the facility admitted Resident #100 on 10/24/2023. According to the Admission Record, the resident had a medical history that included diagnoses of senile degeneration of brain and encounter for palliative care. Resident #100's quarterly MDS, with an ARD of 12/16/2024, revealed that per Section Z0500, the Director of Nursing (DON) did not sign the MDS as complete until 01/06/2025, more than 14 days after the ARD. (continued on next page)

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2025 at 10:42 AM with the DON, the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. MDS Assistant #4 further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 49044 4. An Admission Record revealed the facility admitted Resident #26 on 04/13/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side; nontraumatic subdural hemorrhage; major depressive disorder, single episode; unspecified convulsions; obesity; and other psychoactive substance dependence. Resident #26's MDS history included an annual MDS with an ARD of 12/20/2024, followed by a quarterly MDS with an ARD of 03/10/2025. The MDS history indicated the 03/10/2025 quarterly MDS was In Progress. The MDS history further revealed the resident's next quarterly MDS should have an ARD no later than 03/22/2025 (92 days from the date of the resident's last comprehensive MDS assessment), and was 24 days overdue. Resident #26's quarterly MDS, with an ARD of 03/10/2025, revealed Section C, Section D, and parts of Section J were completed on 03/09/2025; Section K was completed on 03/11/2025; and Sections A, GG, H, P, and S were completed on 03/28/2025. No other sections were completed, and section Z0500 was not signed to indicate the assessment was complete. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055761	A. Building B. Wing	05/01/2025

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2025 at 10:42 AM with the Director of Nursing (DON), the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. MDS Assistant #4 further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. The DON stated Resident #26's quarterly MDS, with an ARD of 03/10/2025, was not considered timely, because the quarterly MDS was not yet completed. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 5. An Admission Record revealed the facility admitted Resident #31 on 08/31/2022. According to the Admission Record, the resident had a medical history that included diagnoses of epilepsy, morbid obesity due to excessive calories, conversion disorder with seizures or convulsions, chronic kidney disease, schizoid personality disorder, major depressive disorder, obsessive compulsive disorder, and attention-deficit hyperactivity disorder. Resident #31's MDS history included a quarterly MDS, with an ARD of 12/06/2024, followed by a quarterly MDS with an ARD of 02/24/2025. Resident #31's quarterly MDS, with an ARD of 02/24/2025, revealed Sections A, B, E, H, L, M, N, O, P, and S and parts of Section J were not completed until 04/18/2025 and Section Q and Section I were not completed until 04/22/2025. Section Z0500 revealed that the Director of Nursing (DON) signed the assessment as complete on 04/24/2025, more than 14 days after the assessment ARD. During an interview on 05/01/2025 at 10:42 AM with the Director of Nursing (DON), the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. She further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. (continued on next page)

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	055761	A. Building B. Wing	05/01/2025

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 6. An Admission Record revealed the facility admitted Resident #110 on 07/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease; mild cervical dysplasia; major depressive disorder; generalized anxiety disorder; schizoaffective disorder, depressive type; and other stimulant dependence. Resident #110's MDS history included a quarterly MDS, with an ARD of 01/09/2025, followed by a quarterly MDS, with an ARD of 03/28/2025. The MDS History indicated the resident's 03/28/2025 quarterly MDS was still In Progress. Resident #110's quarterly MDS, with an ARD of 03/28/2025, revealed that staff had only completed Sections C, D, GG, K, and parts of Section J. Section Z0500 revealed the assessment had not been signed to indicate the assessment was complete. During an interview on 05/01/2025 at 10:42 AM with the Director of Nursing (DON), the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. She further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. The DON stated Resident #110's quarterly MDS, with an ARD of 03/28/2025, was not considered timely. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments. 46133 7. An Admission Record revealed the facility initially admitted Resident #27 on 07/08/2024 and most recently admitted the resident on 08/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure, encounter for palliative care, and chronic kidney disease. Resident #27's quarterly MDS, with an ARD of 02/18/2025, revealed that per Section Z0500, the Director of Nursing did not sign the assessment as complete until 04/25/2025, more than 14 days after the ARD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055761	A. Building B. Wing	05/01/2025

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2025 at 10:42 AM with the Director of Nursing (DON), the MDS Manager, and MDS Assistant #4, the MDS Manager stated she had only been working as the MDS Manager for about three weeks. MDS Assistant #4 stated that each month she reviewed each resident's record to identify who required an MDS, so she could open the assessments. She further stated she had 14 days from the ARD of each assessment for the assessment to be completed. MDS Assistant #4 stated, We are already behind, and further stated that she made a spreadsheet the week prior to try to stay on track with MDS due dates. The DON stated MDS Assistant #4 was new to MDS work and had only been working in the MDS department for the past year. The DON further stated the facility also had part-time staff who were willing to come in to assist with the completion of MDS assessments. The DON stated, I know we are late, and I have been dedicating a lot of my days to doing MDS [assessments]. MDS Assistant #4 stated that as of 05/01/2025, they were working on MDS assessments from the second week of 03/2025. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated he expected MDS assessments to be completed timely. The Administrator stated the facility had experienced some challenges in regard to MDS assessments, and he expected all hands on deck to get caught up. The Administrator stated that he expected MDS staff to follow the RAI manual for submission, completion, and transmission of MDS assessments.

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 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. 49044 Based on interview, record review, and facility policy review, the facility failed to ensure a new Level I Preadmission Screening and Resident Review (PASARR) was submitted after 1 (Resident #110) of 4 sampled residents reviewed for PASARR requirements was diagnosed with additional mental disorders. Findings included: A facility policy titled, Resident Assessment-Coordination with PASARR Program, reviewed/revised in 05/2024, revealed, The facility coordinates assessments with the preadmission screening and Resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The Policy Explanation and Compliance Guidelines specified, 9. Any Resident who exhibits a newly evident possible serious mental disorder, intellectual disability or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II Resident review. An Admission Record revealed the facility admitted Resident #110 on 07/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of generalized anxiety disorder; major depressive disorder, recurrent, moderate; and schizoaffective disorder, depressive type. The Admission Record indicated the diagnosis of generalized anxiety disorder was classified as an admission diagnosis and had an onset date of 07/25/2024, and the diagnoses of major depressive disorder, recurrent, moderate (onset date 08/05/2024) and schizoaffective disorder, depressive type (onset date 10/09/2024) were classified as diagnoses added during the resident's stay. Resident #110's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/09/2025, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated that the resident had active diagnoses of anxiety disorder, depression, and schizophrenia at the time of the assessment and received antipsychotic and antidepressant medications during the seven-day assessment look-back period. Resident #110's Level I PASARR, completed at a local hospital on 07/25/2024, revealed the screening type was an Initial Preadmission Screening (PAS). The resident's medical record revealed no documented evidence that any subsequent Level I PASARRs were completed after the resident was diagnosed with major depressive disorder, recurrent, moderate on 08/05/2024 or after the resident was diagnosed with schizoaffective disorder, depressive type on 10/09/2024. During an interview on 04/29/2025 at 10:58 AM, the Assistant Director of Nursing (ADON) stated she would look to see if she could locate any additional Level I PASARRs for Resident #110. During an interview on 04/29/2025 at 11:09 AM, the ADON confirmed she did not locate any additional Level I PASARRs for Resident #10. The ADON stated the facility should have submitted a Level I PASARR change after the resident was diagnosed with new mental illness. (continued on next page)

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	055761	A. Building B. Wing	05/01/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 9:27 AM, the Director of Nursing (DON) acknowledged the facility was not updating Level I PASARRs when psychiatric diagnoses were added. During an interview on 05/01/2025 at 10:01 AM, the Administrator stated that Level I PASARRs should be updated anytime a resident received additional diagnoses.

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	055761	A. Building B. Wing	05/01/2025

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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 49044 Based on interview, record review, and facility policy review, the facility failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) accurately reflected the presence of a diagnosed mental illness for 1 (Resident #110) of 4 sampled residents reviewed for PASARR requirements. Findings included: A facility policy titled, Resident Assessment-Coordination with PASARR Program, reviewed/revised in 05/2024, revealed, The facility coordinates assessments with the preadmission screening and Resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The Policy Explanation and Compliance Guidelines specified, 1. Applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission. An Admission Record revealed the facility admitted Resident #110 on 07/25/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of generalized anxiety disorder. The Admission Record indicated the diagnosis of generalized anxiety disorder was classified as an admission diagnosis and had an onset date of 07/25/2024. Resident #110's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/01/2024, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated that the resident had an active diagnosis of anxiety at the time of the assessment and received antipsychotic and antidepressant medications during the seven-day assessment look-back period. Resident #110's Level I PASARR, completed at a local hospital on 07/25/2024, revealed the screening type was an Initial Preadmission Screening (PAS). Section III - Serious Mental Illness reflected the resident did not have a serious diagnosed mental disorder, such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance. The Level I PASARR did not reflect Resident #110's diagnosis of generalized anxiety disorder and did not reflect that the resident received psychotropic medications. As a result, the resident's Level I PASARR was considered negative, and a Level II PASARR Evaluation was not required. During an interview on 04/29/2025 at 10:58 AM, the Assistant Director of Nursing (ADON) stated that hospital staff completed the Level I PASARRs, and if there were errors, she or MDS staff completed another Level I PASARR. The ADON stated she would look to see if she could locate any additional Level I PASARRs for Resident #110. (continued on next page)

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	055761	A. Building B. Wing	05/01/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/2025 at 11:09 AM, the ADON confirmed she did not locate any additional Level I PASARRs for Resident #10. The ADON stated she and other facility staff members met during morning meetings to review the Level I PASARRs for accuracy. She stated if they determined the information was not correct, they should complete a new Level I PASARR. After reviewing Resident #110's Level I PASARR, dated 07/25/2024, the ADON stated the resident was admitted with a diagnosis of major depressive disorder, so they should have submitted a corrected Level I PASARR upon the resident's admission to the facility. During an interview on 05/01/2025 at 9:27 AM, the Director of Nursing (DON) stated Level I PASARRs were completed at the hospital prior to admission, and the facility received a copy once a resident was admitted . The DON stated that approximately two months prior, the facility started checking Level I PASARRs, because they noticed the hospitals were missing diagnoses. However, the DON stated they had not gone back to review all PASARRs for accuracy; they only reviewed for accuracy of Level I PASARRs for the most recent admissions. During an interview on 05/01/2025 at 10:01 AM, the Administrator stated that for Level I PASARRs, he expected staff to review them for accuracy, and if they were not accurate, he expected staff to submit a new one.

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	055761	A. Building B. Wing	05/01/2025

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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** 46133 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented interventions as outlined in the resident care plan to minimize or reduce the risk of falls. Specifically, the facility failed to ensure the use of a floor mat for 1 (Resident #107) of 2 sampled residents reviewed for accidents and falls. Findings included: A facility policy titled, Fall Management, dated 08/2014, revealed the section titled, Fall Prevention Procedure, included, 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessment, and while conducting interdisciplinary care plan reviews. 2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. An Admission Record indicated the facility admitted Resident #107 on 06/07/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) as a result of a previous cerebral infarction (stroke) which affected the resident's left side, and generalized anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/11/2025, revealed Resident #107 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. The MDS revealed the resident was dependent on staff for chair/bed-to-chair transfers, going from sitting to lying position, and lying to sitting position. The MDS revealed the residents used a wheelchair during the assessment's lookback period. The MDS revealed the resident had not had a fall since their prior assessment. Resident #107's Care Plan Report, included a focus area dated 06/07/2024, that indicated the resident was at a high risk for falls. Interventions directed staff to place the bed in the lowest position with a floor mat next to the bed (initiated 06/13/2024). A quarterly Risk Fall assessment dated [DATE] indicated Resident #107 had a high risk for falls. During an observation on 04/29/2025 at 2:52 PM, Resident #107 was lying in bed with their call device in bed near their right shoulder. There was no fall mat present on the floor beside the resident's bed. During an observation on 04/30/2025 at 1:17 PM, Resident #107 was lying in bed with no fall mat present on the floor beside the bed. (continued on next page)

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	055761	A. Building B. Wing	05/01/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/2025 at 2:03 PM, Licensed Vocational Nurse (LVN) #8 said Resident #107 would frequently call out verbally and was sometimes confused and thought they needed to get dressed to go to work. LVN #8 said the staff used a fall mat beside the resident's bed and kept the bed in the lowest and locked position. LVN #8 said sometimes the resident could be redirected to use their call device, and other times they were too confused. LVN #8 said that in addition to the use of a fall mat, certified nursing assistants (CNAs) were expected to perform frequent rounding on the resident. During an interview on 04/30/2025 at 1:18 PM, CNA #9 said they were familiar with Resident #107 and said the resident had a high risk for falls. CNA #9 said that when the resident was in bed, it should be in a low position with a fall mat placed on the floor. During a concurrent observation, CNA #9 went into Resident #107's room and noted there was no fall mat present. CNA #9 was unable to locate Resident #107's fall mat in the room. CNA #9 said she had seen a fall mat in the room the previous day but was unsure what had happened to it. During an interview on 04/30/2025 at 1:21 PM, LVN #10 said they were assigned to Resident #107. LVN #10 said Resident #107 was known to crawl out of bed. He said the resident's fall mat may have been moved to their roommate's bed and was not sure why there was not a fall mat present for Resident #107. LVN #10 said he expected CNAs to place a fall mat on the floor when the resident was helped back to bed. LVN #10 said no one had informed him that Resident #107 was back in bed or that there was no fall mat present. During an interview on 05/01/2025 at 12:56 PM, CNA #9 said she checked on Resident #107 every fifteen minutes or so. She said the fall mat was first noticed to be missing the previous day and said they thought the fall mat was there on Monday (04/28/2025). CNA #9 said she was not sure why the fall mat was not present on Tuesday (04/29/2025) or Wednesday (04/30/2025). CNA #9 said the resident was able to use their call light and usually would use it. CNA #9 said the resident was able to make their needs known. CNA #9 said the nurses expected the CNAs to put the fall mat down when the resident was in bed. CNA #9 said CNAs were able to document on interventions like the bed being in a low position, environment free of clutter, and resident belongings being kept within reach, but said they did not document whether the fall mat was in place and thought nurses would be responsible for that. During an interview on 05/01/2025 at 1:09 PM, the Assistant Director of Nursing (ADON) said the fall mat should never leave Resident #107's room. The ADON said nurses would oversee ensuring the fall mat was in place, and said CNAs did not document whether the mat was in place. The ADON said the fall mat should have been at the bedside and placed on the floor beside the bed any time the resident was in bed. During an interview on 05/01/2025 at 1:55 PM, LVN #2 said she was assigned to Resident #107 on Monday (04/28/2025) and remembered seeing the resident's fall mat that day. LVN #2 said they were not sure what happened to the fall mat between Monday (04/28/2025) and Tuesday (04/29/2025). LVN #2 said they would let the CNAs know if a resident needed to have a fall mat put down. During an interview on 05/01/2025 at 2:01 PM, the Director of Nursing (DON) said the CNAs and LVNs were responsible for ensuring interventions were in place when the resident was in bed. The DON said everyone was responsible for noticing if a fall mat was missing and placing one down. The DON said there was a risk of injury if the fall mat was not used properly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 9:19 AM, the Administrator said he was not familiar with Resident #107. The Administrator said if a resident was admitted and was at risk for falls, they expected the resident to be monitored to prevent falls and for interventions to be in place to help prevent falls. The Administrator said he expected nurses to ensure interventions like fall mats were being used.

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	055761	A. Building B. Wing	05/01/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52274 Based on observation, record review, interview, facility document review, and facility policy review, the facility failed to maintain its food service equipment in a clean and sanitary manner related to 1 of 1 low temperature dishwashing machine observed. As a result, the residents of the facility were placed at risk for food borne illnesses. Findings included: An undated facility policy titled, Food & Dining Services Equipment Cleaning Procedures, revealed the section titled, 8. Dish Machine/Dishwasher, included, After every meal: 7. Wipe soap dispenser electrodes, outside of soap dispenser and dish machine with clean, damp cloth. Wipe dry. Further review revealed that the section also included, Dish machine de-liming weekly, with instructions to, 5. Wash any other areas that have build-up. The 04/2025 AM Dishwasher Cleaning Schedule revealed a check-off form with no areas on the form that would indicate the schedule and actual cleaning of the dishwashing machine. The AM Dishwasher Cleaning Schedule revealed that the last time the Dish area walls/fan were checked off as being cleaned was on 04/18/2025. The form indicated that the Dish area walls/fan should be cleaned on Thursdays. An observation of the kitchen on 04/28/2025 at 9:28 AM revealed that the kitchen housed a low-temperature dishwashing machine. Dietary Aide #13 was observed operating the dishwashing machine. Dietary Aide #13 was running the morning meal dishes through the dishwashing machine. The dishwashing machine was noted with a white and brown chalky build-up around the opening of the dirty loading doors, around the opening of the clean exit doors, and covering the top of the dish machine. An observation on 04/30/2025 at 8:04 AM revealed the dishwashing machine was noted with a white and brown chalky build-up around the opening of the dirty loading doors, around the opening of the clean exit doors, and covering the top of the machine. During a concurrent interview, the Certified Dietary Manager (CDM) revealed that the dishwashing machine was cleaned daily and de-limed weekly. The CDM stated he was unsure of the date that the dishwashing machine was last cleaned. The CDM stated the dishwashing machine was not on the check-off form but was typically cleaned when the Dish area walls/fan were cleaned, which would be on Thursdays. The CDM stated that 04/18/2025 would have been the last time the dishwashing machine was cleaned unless staff had forgotten to document that they cleaned it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/01/2025 at 9:24 AM, Registered Dietitian (RD) #5 stated that he was covering for the facility in the absence of their regular RD. The RD #5 stated that his expectation was that kitchen equipment should be clean, usable, and regularly cleaned according to a cleaning schedule. RD #5 stated that the dishwashing machine should be working and clean when in use. RD #5 stated that the machine typically should be checked before use and should be free from hard water build-up. RD #5 stated that the dishwashing machine should have been cleaned before use, and that information should have been documented on the cleaning schedule check-off form that would have stated when the equipment was cleaned or de-limed. RD #5 said he expected staff to clean the dishwashing machine per the cleaning schedule. During an interview on 05/01/2025 at 8:09 AM, the Director of Nursing (DON) stated that her expectation related to cleanliness of equipment in the building was that staff were to follow infection control standards and consult with the Environmental Manager to ensure that all equipment was kept clean, and that training was provided to staff. The DON stated that related to kitchen equipment, the Kitchen Manager and RD were to conduct monthly audits. She said the Kitchen Manager should have been conducting weekly audits, which should have revealed the kitchen's cleanliness and made sure the equipment was clean and functioning. The DON stated that her expectation related to the dishwashing machine was that the machine should have scheduled cleaning, and staff should follow the standards of the dirty and clean process. The DON said she expected the cleaning of the dishwashing machine to be documented in the audits. During an interview on 05/01/2025 at 8:25 AM, the Administrator stated that he expected the equipment to be cleaned, sanitized, and ready to go, and that staff documented when equipment was cleaned and sanitized. The Administrator said he expected kitchen equipment to be cleaned. The Administrator stated he expected the dishwashing machine to be cleaned and sanitized to match the regulation and that it should have been documented each time it was cleaned.

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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. 46133 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff stored respiratory equipment in accordance with the facility policy and standard precautions. Specifically, the facility failed to store nebulizer masks and Continuous Positive Airway Pressure (CPAP) masks in a manner which limited the spread of infection for 2 (Resident #202 and Resident #298) of 2 residents reviewed for respiratory care. Findings included: 1. An undated facility policy titled, Oxygen Therapy and Devices, revealed the section titled, Oxygen Devices, included, 4) Simple Mask f. Place in a labeled bag when not in use. Further review revealed that the policy did not address the use of a nebulizer mask. During an interview on 04/30/2025 at 10:11 AM, the Director of Nursing (DON) said they were still looking for a more specific policy pertaining to the nebulizer masks and acknowledged that the provided policy covered several other types of respiratory masks, but not nebulizer masks. The DON said nebulizer masks should be stored in bags when not in use, just like the other mask types listed in the policy. The DON did not provide any additional policies. An Admission Record indicated the facility admitted Resident #202 on 04/23/2025. According to the Admission Record, the resident had a medical history that included diagnoses of pneumonia, chronic obstructive pulmonary disease (COPD), and hypoxemia (low blood oxygen content). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #202's Order Summary Report, with active orders as of 04/30/2025, included an order dated 04/23/2025, for ipratropium-albuterol inhalation solution 0.5-2.5 3 milligrams (mg) per 3 milliliters (ml), with instructions to have the resident 3 ml inhale orally every 4 hours for COPD exacerbation/Pneumonia While awake. Resident #202's Care Plan Report included a focus area initiated 04/29/2025, that indicated the resident had an altered respiratory status related to their diagnosis of COPD and pneumonia. Interventions directed staff to administer medications as ordered, including puffers. During an interview on 04/28/2025 at 11:01 AM, Resident #202 stated they had pneumonia. During a concurrent observation, a nebulizer mask was observed to be sitting on top of the bedside table unbagged, with other personal items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/29/2025 at 9:01 AM, Resident #202 was observed sitting in a wheelchair, and the nebulizer mask was observed sitting on the bedside table unbagged. The portion of the mask that made contact with the resident's face was observed to be touching the table. During a concurrent interview, Resident #202 stated the mask was for breathing treatments. Resident #202 stated staff put medicine in the nebulizer and managed the equipment. Resident #202 stated they did not know if staff changed out the mask. Resident #202 stated they used the mask twice a day. Resident #202 stated they did not like the mask sitting out on the table and thought it should have been taken and washed. Resident #202 said they did not know why it was sitting on the table. During an observation on 04/29/2025 at 1:31 PM, Resident #202 was observed sitting in a wheelchair. The nebulizer mask was placed on top of an oxygen concentrator unbagged, with the portion of the mask that covered the resident's nose and mouth exposed and touching the concentrator. During a concurrent interview, Resident #202 stated they had received one breathing treatment that morning since they were last interviewed (on 04/29/2025 at 9:01 AM). During an observation on 04/29/2025 at 3:15 PM, Resident #202's nebulizer mask was observed sitting on top of an oxygen concentrator unbagged. There was a clear, undated plastic bag on the back of the concentrator with nothing in it. During an observation on 04/30/2025 at 8:35 AM, Resident #202's nebulizer mask was observed sitting on top of an oxygen concentrator unbagged. During an interview on 04/30/2025 at 9:45 AM, RN #15 said they worked with Resident #202 last night (on 04/29/2025). RN #15 said that regarding the prescribed nebulizer treatments, they placed the liquid medication in the nebulizer and turned on the concentrator for ten minutes. RN #15 said the resident received the medication via a mask which covered their nose and mouth. RN #15 said that due to the resident's age, staff placed the mask on the resident and removed it afterwards. RN #15 said when the nebulizer mask was not being used, it should be kept in a plastic bag. RN #15 said after the breathing treatment was completed last night (on 04/29/2025), he noted the mask looked dirty and added that it may have been dropped during care. RN #15 said he thought he had thrown it away and gotten a new mask, which he placed on the bedside table unbagged. RN #15 then said he was unsure if he ever brought a clean mask back from the supply room. During an observation on 04/30/2025 at 9:43 AM, Resident #202 was in bed and their nebulizer mask was observed to be sitting on top of an oxygen concentrator unbagged. During an observation on 04/30/2025 at 10:03 AM, Resident #202 was lying in bed wearing their nebulizer mask and was receiving a nebulizer treatment. During an observation on 04/30/2025 at 10:14 AM, Resident #202 was sitting in their bed. Their nebulizer mask was observed to be hanging off the side of the bedside table unbagged. During an interview on 04/30/2025 at 10:15 AM, LVN #14 said she was assigned to Resident #202 that morning and had administered their breathing treatment. LVN #14 said she placed the mask on the resident's face and removed the mask afterwards. During the interview, a separate staff member brought a clear plastic bag to LVN #14 who then acknowledged the mask was unbagged. (continued on next page)

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	055761	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 10:23 AM, Certified Nurse Assistant (CNA) #16 said he cared for residents who used oxygen equipment. CNA #16 said he did not do anything with the nebulizer masks and said that the nurses were responsible for the masks. CNA #16 said the nebulizer masks should be stored in a bag, so they were not touching things in the environment. CNA #16 said the CNAs could place the nebulizer masks in a bag if they noticed it sitting out unbagged. During an interview on 04/30/2025 at 1:28 PM, Respiratory Therapist (RT) #17 said that since Resident #202 was not currently on a respiratory program, it would be the responsibility of the nurses who administered the nebulized medications to ensure the mask was stored properly. RT #17 said the mask should be stored in a clear plastic bag, separate from the nasal cannula. During an interview on 04/30/2025 at 10:11 AM, the Director of Nursing (DON) said all oxygen mask types should be stored in a bag when not in use. The DON said nurses should have a plastic bag to place resident's nebulizer masks inside when not in use. The DON said the nurses were responsible for maintaining the masks and equipment. The DON said nebulizer masks should be changed every Wednesday by nurses on the night shift and placed in a bag with a date written on it. The DON said the nebulizer masks should also be changed as needed. The DON said the purpose of ensuring masks were stored in bags was to keep them clean and to prevent the spread of infection. The DON said staff were educated by the Infection Preventionist (IP) on the importance of proper storage of respiratory equipment. The DON said the storage bags were accessible to nursing staff and could be found in the utility rooms. The DON said staff were informed of the location of the bags during orientation. The DON said CNAs could also help store a mask in a bag if they happened to notice it sitting out and there was no medication in the nebulizer. During an interview on 05/01/2025 at 9:10 AM, the Administrator said he knew where the oxygen equipment storage room was but was not familiar with the oxygen and respiratory devices. The Administrator said he thought nurses were responsible for changing nebulizer masks and tubing weekly. The Administrator said he expected staff to ensure oxygen equipment was maintained according to facility policy and stored in bags when not in use to reduce the spread of infection. 52274 2. An undated facility policy titled, Oxygen Therapy and Devices, revealed the section titled, Oxygen Devices, included, 4) Simple Mask f. Place in a labeled bag when not in use. An Admission Record revealed the facility admitted Resident #298 on 04/25/2025. A Skilled Nursing Admission History And Physical, with a service date of 04/28/2025, indicated that Resident #298 had a medical history that included diagnoses of acute hypoxic respiratory failure, pneumonitis, and obstructive sleep apnea. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/29/2025, revealed that Resident #298 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #298's Order Summary Report, with active orders as of 04/29/2025, contained an order, dated 04/26/2025, for supplemental oxygen at 5 liters per minute (LPM) via nasal cannula (NC), continuous every shift for acute hypoxemic respiratory failure. The Order Summary Report contained an order dated 04/25/2025, for staff to connect a continuous positive airway pressure (CPAP) mask to supplemental oxygen delivery source and deliver at the same rate ordered for the continuous supplemental oxygen, every evening shift. The Order Summary Report contained an order dated 04/25/2025, for the resident's CPAP to be on at 9:00 PM and off at 9:00 AM or when the patient awakens. The Order Summary Report contained an order dated 04/25/2025, for ipratropium-albuterol inhalation solution 0.5-2.5 3 milligrams (MG)/3 milliliters (ML), with instructions to inhale orally four times a day for acute respiratory failure/obstructive sleep apnea (ARF)/(OSA). An observation on 04/28/2025 at 10:47 AM of Resident #298 revealed that a CPAP with a mask attached and nebulizer machine with a mask attached was lying in an uncovered box, on top of the resident's bedside table. Both masks were noted not to be bagged. During an interview on 04/28/2025 at 10:47 AM, Resident #298 stated that staff put the masks on and off, and that staff stored the masks in the box. An observation on 04/29/2025 at 8:41 AM of Resident #298 revealed that the resident's CPAP unit was on the overbed table with the CPAP face mask lying flat down on the overbed table next to the CPAP unit. The nebulizer unit was on the overbed table with the nebulizer mask was noted to be face down on the overbed table next to nebulizer unit. During an interview on 04/29/2025 at 8:41 AM, Resident #298 stated that they used the CPAP machine during the night, and the nurse also had to give them a nebulizer treatment during the night. Resident #298 stated that the nurse placed the masks on and off them for the CPAP and the nebulizer treatment. An observation on 04/30/2025 at 8:53 AM of Resident #298 revealed that the resident's CPAP unit was on the overbed table with the CPAP face mask lying flat down on the overbed table next to the CPAP unit. The nebulizer unit was on the overbed table with the nebulizer mask noted to be face down on the overbed table next to nebulizer unit. During an interview on 04/30/2025 at 8:53 AM, Resident #298 stated that the supplemental oxygen they received was good, and they used the CPAP during the night and were given a nebulizer treatment during the night. Resident #298 stated that they did not believe that they were given a nebulizer treatment that morning. Resident #298 stated that they took their CPAP mask off that morning to eat breakfast. Resident #298 stated that the nurse had been in the room that morning to give them their medication. During an interview on 04/30/2025 at 9:00 AM, Certified Nursing Assistant (CNA) #6 stated that as a CNA she checked vital signs and oxygen saturation and checked to see if the resident's oxygen was on and would let the nurse know. She stated that the nurse put nebulizer, supplemental oxygen, and CPAP masks on and off the resident. She stated that it was not a CNA task, and if the masks needed to be put on properly, she would let the nurse know. She stated that the masks were kept in plastic zip-top style bags when not in use. CNA #6 stated that sometimes Resident #298 would take off the different masks themselves but usually asked for staff assistance to take them off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 9:07 AM, Licensed Vocational Nurse (LVN) #7 stated that she had worked at the facility for one month. She stated that the nurses were responsible for placing supplemental oxygen, nebulizer, or CPAP masks on or off the residents based on their orders. She stated that when supplemental oxygen, CPAP, or nebulizer masks were not in use, they should be stored in the resident's room in a bag, which should be labeled. She stated that if the nurse noticed that the masks were not stored properly, the masks should be replaced and then stored in a bag. She stated that related to Resident #298, she did not give a nebulizer treatment that morning but had been in the room to give oral medication and noted that the CPAP and nebulizer masks were on the overbed table. She stated that she could not be sure if they were stored in bags. During a concurrent observation with LVN #7 or Resident #298, the resident's CPAP mask and the nebulizer mask were noted to be lying on the overbed table unbagged. LVN #7 stated that the masks should have been stored in bags. During an interview on 05/01/2025 at 8:56 AM, the Director of Nursing (DON) stated that for residents who used nebulizers, licensed nurses and respiratory therapists were responsible for cleaning and storing the nebulizer mask as well as supplemental oxygen, and they should be in a bag. She stated that every Wednesday the night shift licensed nurses would change the bags and would know if bags were changed by the date on the bag. She stated that bags should also be changed as needed. The DON stated that the purpose of storing the respiratory masks in bags was to keep them clean and to keep them from being contaminated. She stated that the risk related to unbagged respiratory masks would be exposure to bacteria and other things. She stated that that would include oxygen masks, CPAP masks, and all respiratory masks. The DON stated that staff were educated by the Infection Preventionist (IP) on infection prevention related to storage of masks and changing all respiratory equipment weekly. She stated all nurses were trained as to where to find the respiratory equipment. The DON stated that her expectation was that nurses store the masks in bags when not in use, and aides should store the mask in the bags if they noticed it was not appropriately stored. The DON stated that the facility staff also conducted rounds to ensure that things were clean, appropriately stored, and not on the floor. During an interview on 05/01/2025 at 9:10 AM, the Administrator stated that everyone should know where the storage rooms were, and that respiratory equipment should be stored appropriately. The Administrator stated he expected that the respiratory masks be cleaned and stored per the policy.