STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555144	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Pauls Health Care Center	235 Nutmeg Street San Diego, CA 92103

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (1) received continence care in accordance with professional standards, when staff applied two incontinence briefs improperly with the inner brief folded and a hole cut in the center through which the penis protruded.This failure resulted in swelling and pain for Resident 1 that required hospital evaluation and caused psychosocial harm related to embarrassment.Resident 1 was admitted to the facility on [DATE] with diagnoses of prostatic hyperplasia with lower urinary tract symptoms (and enlarged prostate that can block urine flow) and obstructive and reflux uropathy (urine blocked from leaving the body that flows backwards into the kidney) per the facility face sheet. A review of Resident 1's change in condition form, signed 8/3/25 at 12:37 P.M., by licensed nurse (LN) 1, indicated, .Swollen head of penis caused by double briefing of resident by CNA on NOC shift. A small hole was cut into secondary brief and penis pulled through. Upon changing resident CNA day Shift alerted this writer and assessed that the hole was too tight for proper circulation. A review of Resident 1's clinical notes, dated 8/3/25, indicated Resident 1 was found double briefed by the day shift which caused pain and swelling of the meatus of the penis and was subsequently sent to the emergency room via ambulance at 1:10 P.M. A review of the hospital after visit summary, dated 8/3/25, indicated Resident 1 was diagnosed with Paraphimosis (a medical emergency where the foreskin becomes stuck behind the penis head leading to swelling, pain and tissue death if not corrected). During an observation and interview on 8/14/25 at 11:33 A.M., Resident 1 was lying in bed with eyes open and was oriented to person and place. A call bell was on the bed beside Resident 1's left arm. Resident 1's left hand and wrist appeared stiff and contracted. Resident 1 stated he had little movement on his left side, and he was unable to reach the call bell. Resident 1 stated he wore briefs and was unable to control his urine but knew when he was wet. Resident 1 looked away and did not respond when asked if staff had ever provided improper incontinence care or applied briefs incorrectly. Resident 1 stated the facility used a lot of registry staff when they were short-staffed and that the care during the day was acceptable, but it was not as good at night. Resident 1 stated if the call bell was out of reach, he just waited for staff to come into the room. Resident 1 declined to provide additional information. During an interview on 8/14/25 at 1:16 P.M., certified nursing assistant (CNA) 1 stated Resident 1 usually communicated well, but on the morning of 8/3/25 was less talkative than usual. CNA 1 stated as she was performing incontinence care for Resident 1, she found a second brief underneath the outer brief. CNA 1 stated the outer brief was applied normally , while the inner brief was still folded like it just came out of the package, with a hole cut through the center and the resident's penis protruding through the opening. CNA 1 stated the top of the penis appeared swollen and red, and that Resident 1 reported it was painful. CNA 1 stated she immediately notified the charge nurse (LN 1) who came to assess Resident 1. CNA 1 stated the folded brief was removed but the penis was still swollen. CNA 1 stated Resident 1 stated he was upset with her for informing the charge nurse. CNA 1 stated Resident 1 appeared embarrassed and did not want to talk about who put the briefs on that way. During an interview on 9/3/25 at 11:05 A.M., LN 1 stated on the morning of 8/3/25 CNA 1 notified him she was concerned about Resident 1's brief placement. LN 1 stated he observed CNA 1 remove Resident 1's outer brief and saw a folded brief with a hole cut through the middle and Resident 1's meatus sticking through the hole. LN 1 stated Resident 1's penis appeared swollen and discolored and the opening was so tight it was acting like a rubber band. Resident 1 was guarded during the physical assessment. LN 1 stated the practice of putting a resident in two briefs was not acceptable and was considered a form of neglect. LN 1 stated there was visible skin breakdown where the brief was restricting the tip of the penis. LN 1 stated the person who placed Resident 1 in the briefs was identified as the overnight (NOC) CNA from registry (a staffing agency). During an interview on 9/4/25 at 4:20 P.M., the nurse administrator (NA) stated she had completed the internal investigation of the alleged abuse involving Resident 1 and found that NOC CNA was responsible for double briefing the resident. NA stated double briefing should never be done because it increases the risk of skin breakdown. NA stated it was the facility's policy to never double brief residents and all CNAs were expected to be competent and implement best practices. The NA stated registry staff should complete their competencies before coming to work on the floor. NA stated she was unable to find any type of documentation that verified NOC CNA's competencies were completed before working at the facility. NA acknowledged Resident 1 experienced psychosocial harm from embarrassment and reported pain as well as potential for injury because NOC CNA

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff were competent to provide continence care for 1 of 1 sampled residents (1) when competency validation records were not maintained for a night shift (NOC) certified nursing assistant (NOC CNA) from registry (a staffing agency) who was identified in the facility's internal investigation as having improperly applied incontinence briefs. This failure resulted in registry staff providing care without verified competency, which contributed to improper continence care, swelling, pain and psychosocial harm requiring hospital evaluation for Resident 1. Resident 1 was admitted to the facility on [DATE] with diagnoses of prostatic hyperplasia with lower urinary tract symptoms (and enlarged prostate that can block urine flow) and obstructive and reflux uropathy (urine blocked from leaving the body that flows backwards into the kidney) per the facility face sheet.A review of Resident 1's change in condition form, signed 8/3/25 at 12:37 P.M., by licensed nurse (LN) 1, indicated, .Swollen head of penis caused by double briefing of resident by CNA on NOC shift. A small hole was cut into secondary brief and penis pulled through. Upon changing resident CNA day Shift alerted this writer and assessed that the hole was too tight for proper circulation.A review of Resident 1's clinical notes, dated 8/3/25, indicated Resident 1 was found double briefed by the day shift which caused pain and swelling of the penis and was subsequently sent to the emergency room via ambulance at 1:10 P.M.During an interview on 8/14/25 at 1:16 P.M., certified nursing assistant (CNA) 1 stated Resident 1 usually communicated well, but on the morning of 8/3/25 was less talkative than usual. CNA 1 stated as she was performing incontinence care for Resident 1 she found a second brief underneath the outer brief. CNA 1 stated the outer brief was applied normally , while the inner brief was still folded like it just came out of the package, with a hole cut through the center and the resident's penis protruding through the opening. During an interview on 9/3/25 at 11:05 A.M., licensed nurse (LN) 1 stated he was a registry nurse who had worked at the facility. LN 1 stated on the morning of 8/3/25 CNA 1 notified him she had found Resident 1 wearing 2 briefs. LN 1 stated on observation he found one brief placed over a second folded brief with a hole cut through the middle and the tip Resident 1's penis sticking through the hole. LN 1 stated Resident 1's penis appeared swollen and discolored and the opening was so tight it was acting like a rubber band. LN 1 stated upon investigation it was discovered a NOC CNA from registry had placed the two briefs on Resident 1. LN 1 stated he did not receive any formal orientation or training from the facility before working on the floor. LN 1 stated he did not receive any facility-specific policies and did not receive the facility's abuse prevention policy prior to starting shifts on the floor.During an interview on 9/4/25 at 1:47 P.M., CNA 2 stated she was a full-time staff at the facility. CNA 2 stated it was not a facility practice to have registry CNA's shadow a staff CNA before they worked on the floor.During an interview on 9/14/25 at 2:18 P.M., LN 2 stated she was a full-time staff at the facility. LN 2 stated when registry CNAs worked at the facility, they did not receive formal training or orientation from the charge nurses or nursing staff. During an interview on 9/4/25 at 3:08 P.M., registry CNA 3 stated the facility did not require him to complete any type of skills checklist before he began working on the floor. Registry CNA 3 stated he had not completed a facility-specific skills checklist through the registry company.During an interview on 9/4/25 at 4:20 P.M., the nurse administrator (NA) stated she completed the internal investigation of the alleged abuse involving Resident 1 and found that NOC CNA was responsible for double briefing the resident. The NA stated registry staff should complete their competencies before coming to work on the floor. NA stated she was unable to find any type of documentation that verified NOC CNA's competencies were completed before working at the facility. NA acknowledged Resident 1 experienced psychosocial harm from embarrassment and reported pain as well as potential for injury because NOC CNA applied two briefs in an unsafe manner. NA stated the facility was unable to guarantee the safety of their residents if standards of care were not being met. A record review of the facility submitted a skills checklist provided by the registry company from a different long-term care provider not connected to the facility. The skills check list was signed by the NOC CNA on 8/20/25, after the CNA had been terminated from the facility on 8/5/25. Additionally, the check list was incomplete and for an unrelated long-term care facility and provided no evidence of assessment or supervisory validation signatures for each competency. The facility did not provide a policy on the utilization of registry staff upon request.