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	02/07/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents rights were honored for one of three sampled residents (Resident 5), when the facility asked Resident 5's representative to sign a waiver in response to missing dentures.This failure caused Resident 5 to experience delay in having her lost dentures replaced and had the potential for Resident 5's property to not be safeguarded against loss, theft, or misappropriation.Findings:Resident 5's record was reviewed. According to the Face Sheet, Resident 5 was admitted on [DATE] with diagnoses which included dementia (the loss of cognitive functions such as thinking, remembering, and reasoning) and dysphagia (difficulty swallowing). According to the Minimum Data Set (MDS- a federally mandated assessment tool) dated 12/2/25, Resident 5 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition, or thinking skills) of 3, which indicated Resident 5 had severe cognitive impairment.During a concurrent interview and record review with Licensed Nurse (LN) 1 on 2/7/26 at 7:36 A.M., LN 1 stated Resident 5's dentures had been lost since 1/24/26. LN 1 stated the dentures had not yet been replaced, but Resident 5 had a dental referral which was made on 1/26/26.During a telephone interview with Resident 5's Responsible Party (RP) 1 on 2/7/26 at 9:03 A.M., RP 1 stated the facility agreed to pay to have Resident 5's dentures replaced, on the condition that RP 1 signed a waiver. RP 1 stated the waiver released the facility from any responsibility for any lost, missing, or damaged items prior and up to 2/6/26. RP 1 stated she was not comfortable signing the waiver.During an interview with the Administrator (ADM) on 2/7/26 at 9:50 A.M., the ADM stated the facility agreed to pay for Resident 5's replacement dentures and provided RP 1 with a waiver and release to sign. The ADM stated the facility determined it was Resident 5's fault, not the facility's, the dentures were lost.During a telephone interview with the Dentist (DEN) 1 on 2/10/26 at 9:20 A.M. DEN 1 stated Resident 5 was scheduled to have dental impressions done at the facility later that day between 1 P.M. and 5 P.M. DEN 1 stated he was instructed by the facility not to come to the facility until RP 1 signed the waiver. During a follow up telephone interview with RP 1 on 2/10/26 at 5:02 P.M., RP 1 stated Resident 5's dentist was scheduled to arrive at the facility between 1 P.M. and 5 P.M. to perform Resident 5's dental impressions for replacement. RP 1 stated the dentist did not show up to the skilled nursing facility for the scheduled appointment with Resident 5. RP 1 further stated she had not signed the release waiver provided by the facility.During a telephone interview with the Social Services Director (SSD) on 2/11/26 at 3:30 P.M., the SSD stated acknowledged the facility provided RP 1 with a waiver, which the facility required her to sign prior to proceeding with the dental impressions. The SSD also stated Resident 5 was scheduled to have dental impressions taken on 2/10/26, but cancelled the appointment because RP 1 refused to sign the waiver. The SSD stated, [RP 1] didn't want to sign [the waiver].she said why would I sign it? The SSD stated, The right thing to do was to go ahead and schedule [the dentist].the resident was put in the middle of it.at the end of the day it's the resident that matters. The (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oral care/dentures were provided prior to serving breakfast to one of three sampled residents (Resident 1).This failure had the potential for Resident 1 to experience health complications including choking, aspiration (food enters airway and lungs).Findings:During a record review on 2/7/26, the Face Sheet indicated Resident 1 was admitted on [DATE] with diagnoses which included dysphagia (difficulty swallowing) following a cerebral infarction (a stroke) and type 2 diabetes.During a record review on 2/7/26, the Minimum Data Set (MDS- a federally mandated assessment tool) indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition, or mental processes) of 8, which indicated severe cognitive impairment. The MDS further indicated Resident 1 required substantial assistance with oral hygiene.During a record review on 2/7/26, Resident 1's Physician's Order indicated, Dependent with all meals.On 2/7/26 at 8:10 A.M., a concurrent observation and interview was conducted in Resident 1's bedroom. Resident 1 was sitting up in bed and was being fed by Certified Nursing Assistant (CNA) 1. An open denture cup was observed on Resident 1's nightstand with a pair of dentures inside the cup. CNA 1 stated the dentures must belong to Resident 1 because Resident 1 did not have a roommate. CNA 1 stated she did not know that Resident 1 wore dentures and did not provide oral or denture care prior to breakfast. CNA 1 continued to feed Resident 1 breakfast without placing his dentures in his mouth.On 2/7/26 at 8:13 A.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 should have been assisted with placing the dentures in his mouth prior to eating breakfast. LN 1 stated it was important that Resident 1 wore dentures while eating to be able to chew his food and avoid any choking.During a telephone interview with the Director of Nursing (DON) on 2/12/26 at 11:07 A.M., the DON stated it was her expectation that dentures were placed in Resident 1's mouth prior to every meal. The DON stated it was important that residents' dentures were provided prior to meals, .so they can consume an adequate amount of food and the texture that they like. We don't want them to choke or aspirate. During a review of the facility's policy titled Dentures, Cleaning and Storing dated 2/20/25, the policy indicated, Provide denture care before breakfast and at bedtime.Encourage the resident to keep the dentures in his or her mouth as much as possible. When dentures are left out of the mouth for several days, the bone structure to the mouth changes and the gums will shrink causing the dentures to fit improperly.During a review of the facility's policy titled Dental Services, dated 3/2025, the policy indicated, Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective monitoring, and evaluation of nutritional and hydration needs for 2 of 3 sampled Residents (Resident 2 and Resident 3).1.) Resident 2 experienced a change in oral intake when he was observed pocketing his food (holding food inside the mouth, without chewing or swallowing). The RD did not reassess Resident 2 to determine appropriate interventions, the IDT (IDT- an interdisciplinary team comprised of professionals from various disciplines who work in collaboration to address a resident with multiple physical and psychological needs) did not address Resident 2's change in dietary needs and possible risks to Resident 2's health. Resident 2's care plan did not reflect the pocketing food nor interventions were implemented.2.) Resident 3 experienced poor intake of food and fluids and was determined to be at higher risk for dehydration (the loss of water and electrolytes from the body that prevents it from functioning normally). The facility did not monitor Resident 3's total daily fluid intake to ensure adequate fluids were being consumed.These failures places Resident 2 and Resident 3 at risk for dehydration and to experience a decline in health.Findings:1.) According to a record review of Resident 2's Face Sheet, Resident 2 was admitted to the facility on [DATE] and discharged on 11/25/25 with diagnoses which included hemiplegia (weakness on one side of the body) following cerebral infarction (stroke), aphasia (the inability to speak) following cerebral infarction, and dysphagia (difficulty swallowing). According to Resident 2's Minimum Data Set (MDS- a federally mandated assessment tool) dated 9/2/25, Resident 2 had a Brief Interview for Mental Status (BIMS- a tool to measure cognition skills) of 3, which indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 was dependent on staff for all ADL's (Activities of Daily Living- such as eating, dressing, transferring, and bathing). The MDS further indicated Resident 2 had no swallowing disorders, such as holding food in mouth/cheeks or residual food in mouth after meals.During an interview with Certified Nursing Assistant (CNA) 1 on 1/13/26 at 10:11 A.M., CNA1 stated she had worked with Resident 2 as his CNA. CNA1 stated Resident 2, always needed help with feeding. CNA1 stated, I noticed he wasn't interested in his food or eating towards the end [of his stay at the facility]. He was congested and choked sometimes while eating. Towards the end, he was pocketing his food and coughing but it was not a normal thing.During a concurrent interview and record review with the Registered Dietitian (RD) 1 on 1/30/26 at 1:26 P.M., the RD stated on 11/23/25, Resident 2 had a change in condition and was noted to be pocketing food during meals. The RD stated pocketing food placed Resident 2 at risk for not meeting food and fluid intake, which could lead to dehydration, weight loss, and a possible shift in electrolytes. The RD further stated pocketing food also placed Resident 2 at risk for aspiration. The RD stated she did not see that the IDT met to discuss Resident 2's change of condition, and there was no new nutritional assessment done.During a review of the facility policy titled Resident Hydration and Prevention of Dehydration dated 3/2025, the policy indicated, This facility will strive to provide adequate hydration and to prevent and treat dehydration.The dietitian will assess all residents for hydration as part of the comprehensive assessment quarterly, and more often as necessary per resident need.If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan.Nursing will monitor and document fluid intake and the dietitian will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and relating factors are resolved. 2.) According to the Face Sheet, Resident 3 was admitted on [DATE] and discharged on 1/21/26 with diagnoses which included severe protein-calorie malnutrition and dysphagia.According to the Minimum (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Data Set (MDS- a federally mandated assessment tool) dated 11/28/25, Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to measure cognition skills) of 13, which indicated Resident 3 was cognitively intact. The MDS indicated Resident 3 required supervision for eating. The MDS further indicated Resident 3 had no swallowing disorders, such as holding food in mouth/cheeks or residual food in mouth after meals.During a concurrent observation and interview with Restorative Nursing Assistant (RNA) 1 on 1/12/26 at 11:09 A.M., Resident 3 was observed laying in bed, flat on his back with his eyes closed. There was a small cup of a thick pink liquid on his bedside table. There was a plastic spoon next to the cup. RNA 1 stated the cup of liquid was for the 10 A.M. nourishment pass, which was provided to residents daily between 10 A.M. and 10:30 A.M. RNA 1 stated the nourishment pass was intended to provide extra fluids and snacks to residents, to avoid dehydration and weight loss. RNA 1 stated it looked like Resident 3 consumed less than half of his drink.During a concurrent interview and record review with RD 1 on 1/30/26 at 1:26 P.M., the RD stated Resident 3 was seen by a speech therapist on 1/9/26. The RD further stated per speech therapy, Resident 3 could only consume liquids with a spoon for safety. RD 1 stated this placed Resident 3 at higher risk for dehydration. RD 1 stated per the Nutritional Screening and assessment dated [DATE], Resident 3 required between 1875ml and 2188ml of fluids to be adequately hydrated. Per the ADL Verification Worksheet, on 1/11/26, Resident 3 consumed 236ml of fluids but there was no documented fluid intake for 1/12/26 or 1/13/26. The RD stated Resident 3 did not meet the minimum fluid intake requirements between 1/11/26 and 1/13/26, therefore he was not adequately hydrated.During an interview with the Director of Nursing (DON) on 1/30/26 at 3:25 P.M., the DON stated CNA's were only documenting fluid intake during meals, but there was no other documentation of Resident 3's fluid intake during med pass or nourishments. The DON stated it was important to document all fluid intake to ensure Resident 3 was receiving enough fluids, especially when Resident 3 was at risk for dehydration. The DON stated it was her expectation for staff to offer fluids to residents and document to ensure they are meeting their minimum fluid requirements.During a review of the facility's policy titled Resident Hydration and Prevention of Dehydration dated 3/2025, the policy indicated, Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care.Intake will be documented in the medical records.Aides will report intake of less than 1200ml/day to nursing staff.