STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555206	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Creek Post Acute	12696 Monte Vista Road Poway, CA 92064

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to develop a resident's (Resident 4) baseline care plan (detailed plan with information about a patient's treatment, goal, and interventions) for one of one resident reviewed, related to the placement of a used urinal on top of the meal tray table. As a result, the lack of resident centered care plan with specific interventions to prevent contamination of the surface and the lack of education to Resident 4 had the potential for Resident 4 to acquire an infection. Findings: An unannounced onsite to the facility was conducted on 7/9/24 related to a complaint on physical environment and infection control. Resident 4 was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar), per the facility's Admission Record. On 7/9/24, Resident 4's clinical record was reviewed. Resident 4's history and physical dated 5/18/24 indicated Resident 1 had the capacity to understand and make decisions. Resident 4's minimum data set (MDS, an assessment tool) dated 4/29/24 indicated Resident 1 had a brief interview for mental status (BIMS, ability to recall) score of 10/15 (A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment) which meant Resident 4 had a moderately impaired cognition. During an observation and an interview of Resident 4 in his room on 7/9/24 at 11:21 A.M., Resident 4 laid in bed watching a television show. There was a urinal with a third of yellow urine output on top of the meal tray table. Beside the urinal was a cup with a straw. Resident 4 stated the staff placed the used urinal on top of the meal tray table. Resident 4 stated he used the same table for meals. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint observation and an interview with a certified nursing assistant (CNA) 1 on 7/9/24 at 11:35 A.M., CNA 1 stated Resident 4 placed the used urinal on top of the meal tray table. During a joint interview and record review with Infection Preventionist (IP) on 7/9/24 at 12:14 P.M., the IP stated the urinals should not have been on top of the bedside tables. The IP stated it was important to prevent spread of infection. The IP stated if the resident preferred to place the urinal on top of the meal tray table, the resident should have been educated related to infection prevention and a care plan should have been developed to indicate education was provided to the resident. The IP stated there was no care plan developed for Resident 4 about his preference to place the used urinal on the meal tray table. During an interview with the Assistant Director of Nursing (ADON) on 7/9/24 at 12:52 P.M., the ADON stated the urinals should not have been in the bedside table for infection control practices. The ADON stated the staff should have communicated what the resident preferred and there should be a care plan for Resident 4 about his preferences. Per the facility's policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 1. services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to implement their infection control program when a used urinal was placed on top of the resident's meal tray table for one of four sampled residents (Resident 1). This failure had the potential for contamination of the surface and could cause an infection to Resident 1. Findings: An unannounced onsite to the facility was conducted on 7/9/24 related to a complaint on physical environment and infection control. Resident 1 was readmitted to the facility on [DATE] with diagnoses which included aftercare following a surgery and diabetes (high blood sugar), per the facility's Admission Record. On 7/9/24, Resident 1's clinical record was reviewed. Resident 1's history and physical dated 5/18/24 indicated Resident 1 had the capacity to understand and make decisions. Resident 1's minimum data set (MDS, an assessment tool) dated 5/28/24 indicated Resident 1 had a brief interview for mental status (BIMS, ability to recall) score was 15/15 (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment) which meant Resident 1 had an intact cognition. During an observation and an interview of Resident 1 in his room on 7/9/24 at 11:09 A.M., Resident 1 was sitting up in a wheelchair. There was a used urinal on top of the meal tray table where a jar of olives laid. Resident 1 stated the staff from the previous shift placed the used urinal on top of the meal tray table. Resident 1 stated he used the same table for meals. Resident 1 stated That is where I eat. It was unsanitary. During a joint observation and an interview with rehabilitative nursing assistant (RNA) 1 on 7/9/24 at 11:12 A.M., RNA 1 stated, I just came in with bad situation. That is not what we usually do, I don't know what to say. It is for infection control. During an interview with Infection Preventionist (IP) on 7/9/24 at 12:14 P.M., the IP stated the urinals should not have been on top of the meal tray tables. The IP stated it was important to prevent spread of infection. During an interview with the Assistant Director of Nursing (ADON) on 7/9/24 at 12:52 P.M., the ADON stated the urinals should not have been in the meal tray table for infection control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy titled Infection Prevention and Control, revised December 2023, The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .