

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Carmel Mountain Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11895 Avenue of Industry San Diego, CA 92128	

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)
<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980</p> <p>Based on interview and record review, one resident (Resident 1) was served a food item inconsistent with the prescribed therapeutic diet.</p> <p>This failure had the potential to cause Resident 1 difficulty swallowing safely.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (a medical condition that causes partial or total paralysis of one side of the body) following cerebral infarction (a serious condition that causes brain tissue to die) affecting left side, generalized muscle weakness, and dysphagia (swallowing difficulty).</p> <p>On 8/22/24 the State Agency (SA) received a complaint that indicated Resident 1 was served a bowl of soup that was not pureed per the ordered therapeutic diet.</p> <p>On 8/28/24 a telephone interview was conducted with the Ombudsman (an official who investigates concerns and facilitates solutions) prior to facility entrance. The Ombudsman stated on 8/21/24 Resident 1 had an order for pureed (blenderized) food but was served chicken soup with rice and carrots that was not the correct texture.</p> <p>On 9/5/24 at 12:15 P.M. an interview was conducted with the Director of Nursing (DON) who stated the kitchen accidentally sent out chicken with rice soup without pureeing it. The DON stated a Certified Nursing Assistant (CNA) noticed the error and removed the incorrect soup.</p> <p>A concurrent record review of Resident 1 ' s orders indicated, Regular puree thin liquid diet fortified.</p> <p>A concurrent review of Resident 1 ' s care plan for nutrition indicated an intervention of Diet as ordered.</p> <p>A concurrent review of Resident 1 ' s care plan regarding the soup indicated Resident was given an inappropriate diet. Interventions: all staff to be informed of resident ' s special dietary and safety needs. Diet to be followed as prescribed. Kitchen to use clear plastic cover for the bowl to verify proper diet.</p> <p>(continued on next page)</p>

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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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A concurrent review of Resident 1 ' s History and Physical dated 8/13/24 indicated puree diet.8/21/24: inappropriate food served.</p> <p>A concurrent review of Resident 1 ' s Change of Condition note dated 8/21/24 indicated, Charge nurse were [sic] called in the dining room by the RP (Responsible Party) regarding resident ' s diet. It was noted that resident ' s soup was not appropriate diet for the resident. Resident was on puree and thin liquid diet.</p> <p>On 9/12/24 a review of Resident 1 ' s Speech Therapy evaluation and plan of treatment dated 8/13/24 indicated Diet recommendation - puree consistencies.</p> <p>On 9/13/24 at 11:40 A.M. an observation and interview were conducted in the kitchen with the Certified Dietary Manager (CDM) with the Skilled Nursing Facility Coordinator (SNFC). The CDM stated, A mistake was made, someone grabbed the wrong soup and put it on the tray.</p> <p>A review of a facility policy entitled Healthcare Menus Direct LLC 2023 indicated, Tray card system: Each meal tray at breakfast, lunch, and dinner will have a tray card which designates the resident ' s name, diet .</p> <p>A review of an undated facility policy entitled Feeder indicated, Check contents to make sure you have the correct tray.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980</p> <p>Based on observation, interview and record review, the facility failed to follow its COVID-19 mitigation plan when:</p> <ol style="list-style-type: none"> 1. front desk staff did not request people who entered the facility to wear a mask during a COVID-19 outbreak (at least three confirmed positive cases within a seven day period). 2. Infection Preventionist (IP) 1 allowed a visitor into the COVID-19 isolation area without an n95 mask (a highly protective respiratory mask). 3. Floor staff did not stop unmasked visitors to ask them to wear a mask while inside the facility. 4. Licensed Nurse (LN) 1 had a mask under her chin when she entered a patient room. 5. A Certified Nursing Assistant (CNA) and a Receptionist were unmasked in a hallway. 6. All but two kitchen staff were unmasked in the kitchen during lunch preparation. <p>These failures had the potential to infect vulnerable residents with COVID-19.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (a medical condition that causes partial or total paralysis of one side of the body) following cerebral infarction (a serious condition that causes brain tissue to die) affecting left side, generalized muscle weakness, and dysphagia (swallowing difficulty).</p> <p>On 8/22/24 the State Agency (SA) received a complaint that indicated Resident 1 was seated next to another resident who was positive for COVID-19.</p> <p>On 8/28/24 a telephone interview was conducted with the Ombudsman (an official who investigates concerns and facilitates solutions) prior to facility entrance. The Ombudsman stated there were five COVID-19 positive residents when she was at the facility on 8/21/24. The Ombudsman stated staff and visitors were unmasked in the facility. The Ombudsman further stated there were nine COVID-19 positive residents on 8/23/24 and two COVID-19 positive room doors open while she was onsite.</p> <p>On 9/4/25 at 12:05 P.M. an unannounced visit to the facility was conducted. The Receptionist did not ask people entering to put on a mask.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/4/24 at 12:25 P.M. a walking tour of the facility was conducted with the Director of Nursing (DON). The DON stated, Residents are being moved to one area because we have a COVID outbreak right now, we just did testing this morning. A joint observation at the door of the COVID-19 unit was conducted with the DON and Infection Preventionist (IP) 1. IP 1 stated that visitors must wear an n95 mask inside the COVID-19 unit. IP 1 opened the door to the COVID-19 unit and allowed a visitor inside without wearing a mask. IP 1 did not ask the visitor to put a mask on prior to entry. After the issue was pointed out to the DON and IP 1, IP 1 asked the visitor to put a mask once she was inside the COVID-19 unit. The door to the COVID-19 unit did not have a sign indicating a mask must be worn prior to entry.</p> <p>On 9/4/24 at 12:50 P.M. a concurrent record review was conducted with the DON and IP 1. Resident 1 ' s orders included Start Paxlovid (an antiviral therapy used to treat COVID-19) 9/4/24. Confirmed COVID 9/4/24.</p> <p>On 9/5/24 at 9:20 A.M. a telephone interview with IP 1, IP 2 and the DON was conducted. IP 2 stated, Every part of the facility is a resident care area, and masks should be worn at the desk, in the hallways, at the entrance of the facility. IP 1 stated, We have the Receptionist who offers visitors a mask and explains to them that they should be masking and do hand hygiene to reduce risk for infection. Current outbreak is 22 residents.</p> <p>On 9/11/24 at 11:25 A.M. a call was received from the complainant who stated, (Resident 1) was sent back to (hospital name). He was sent out for confusion. His roommate was COVID positive.</p> <p>On 9/11/24 at 11:43 A.M. a call was made to the DON who stated, (Resident 1) went to (hospital name) ED (Emergency Department) yesterday and is returning today. His roommate was COVID positive. The NP (Nurse Practitioner) and MD (Medical Doctor) saw (Resident 1) and were concerned about confusion and slurred speech. COVID testing was done this morning, we have two new positives.</p> <p>On 9/13/24 at 10:15 A.M. a second visit was made to the facility.</p> <p>On 9/13/24 at 10:20 A.M. an observation of an unmasked visitor in a hallway was conducted. The visitor stated no staff asked him to mask. At 10:45 A.M. the same visitor was observed in the therapy room unmasked. No therapy staff asked him to wear a mask.</p> <p>On 9/13/24 at 10:30 A.M. an observation and interview were conducted outside room [ROOM NUMBER] with LN 1 who wore a surgical mask below her chin. LN 1 entered and exited room [ROOM NUMBER] with the mask below her chin. LN 1 stated, The rooms are patient care areas. There is COVID in the building. I should have had my mask all the way up over my nose.</p> <p>On 9/13/24 at 11:00 A.M. a joint observation and interview with IP 1 and Skilled Nursing Facility Coordinator (SNFC) was conducted of CNA 1 unmasked by the timeclock. CNA 1 stated, I should wear a mask in the building.</p> <p>On 9/13/24 at 11:05 A.M. a joint observation and interview with IP 1 and the SNFC was conducted of the Receptionist unmasked near bathroom. The Receptionist stated, I was going to the bathroom. The Receptionist was also observed unmasked at front desk. The Receptionist stated, I ' m not in a patient care area.</p> <p>(continued on next page)</p>		

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