STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555326	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Mountain Rehabilitation & Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure temperature was addressed and notified physician for one of two residents in a timely manner. These failures resulted in a delay of assessment and treatment for Resident 1. Findings: Resident 1 was admitted to the facility on [DATE], according to the facility admission Record. On 9/4/25 at 2:57 P.M., a concurrent interview and record review were conducted with the Director of Staff Development (DSD) and Licensed Nurse (LN) 1. LN 1 stated normal body temperature within 97 to 99 degrees Fahrenheit (F). According to the History and Physical Examination (H&P) by the physician on 12/10/24 and with diagnoses to include hypothermia (body drops below 95 degrees Fahrenheit (F). According to the facility change of condition evaluation dated 12/14/24 at 12 P.M., .Resident was noted to have low temperature @ 9.30am[sic] w/ readings at 92 and was rechecked at around 11am with readings at 90.2, resident was noted shivering and skin is cold. According to physician orders dated 12/14/24 at 11:59 A.M., transfer to hospital due to hypothermia. During this interview and record review, LN 1 started receiving a report from a Certified Nurse Assistant (CNA) on 12/14/24 around 9:30 A.M. Resident 1's temperature was 92 F. LN 1 stated she was busy during that time and asked the CNA to take Resident 1's temperature. LN 1 stated around 11:49 A.M., Resident 1's temperature was 90.2 F. LN 1 stated she started a change of condition and informed the physician around 12 P.M. and Resident 1 was transferred to the emergency room via 911. LN 1 stated she should have assessed Resident 1 temperature right away. On 9/4/25 at 5:20 P.M., a concurrent interview and record review were conducted with LN 2. LN 2 stated she was approached by resident 1'a family member to check Resident 1's temperature. LN 2 stated this was about lunch time around 12 P.M. LN 2 stated Resident 1 was sitting in his room and a blanket wrapped around him. LN 2 stated Resident 1's low temperature should be addressed and notify the physician right away. On 9/4/25 at 5:42 P. M., an interview with the Director of Nursing (DON) was conducted. The DON stated she should notify the physician right away because Resident 1's hypothermia was a medical emergency. The DON stated Resident 1's temperature of 92 F was not normal. According to the facility policy entitled Section: Care and Treatment Subject: Change of Condition Reporting, revised date 6/2013, indicated. all changes in resident condition swill be communicated to the physician.1. All symptoms and unusual sings will be communicated to the physician promptly.

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medications on time to 50 of 113 residents during a planned power outage.This failure had the potential to affect the health and well-being of the residents. Findings:A consumer complaint was filed with the California Department of Public Health alleging that on 8/10/25, Resident 1 had not received medications as prescribed.An interview was conducted with the Assistant Director of Nursing (ADON) on 8/11/25 at 1:50 P.M. The ADON stated the facility had experienced a planned power outage on 8/10/25, and nursing staff was unable to use the electronic Medication Administration Record (eMAR) to provide medications to all residents. The ADON stated 50 of the 113 residents who resided in the facility on 8/10/25 received their scheduled morning medications after the power came back on, approximately 10 A.M. The ADON stated she had spoken to Resident 1's family members, who wanted to remove the resident from the facility due to the medication problems.An interview was conducted with Licensed Nurse (LN) 1 on 8/11/25 at 2:15 P.M. LN 1 stated she was assigned to Resident 1 on 8/10/25, and had provided her medications once the power was on. LN 1 stated the medications were scheduled for 9 A.M., which meant they had to be administered between 8 A.M. and 10 A.M. to be considered on time. LN 1 stated Resident 1's medications were given late, at approximately 11 A.M. LN 1 stated, It is important to give certain medications at the right time, we didn't do that. There could be a risk to the resident's health.A record review was conducted on 9/4/25.Resident 1 was admitted to the facility on [DATE] with diagnoses to include Parkinson's Disease (a movement disorder of the nervous system that worsens over time), per the admission Record.Resident 1 was prescribed the following medications for 9 A.M.:Thiamine (a vitamin), administered at 12:26 P.M.Vitamin D3, administered at 12:26 P.M.Rivaroxaban (a medication to prevent blood clots), administered at 1:08 P.M.Calcium (a mineral), administered at 12:26 P.M. Resident 1 was prescribed the following medications for 11 A.M.:Rytary (a medication for Parkinsons Disease), administered at 12:15 P.M.An interview was conducted with the Director of Nursing (DON) on 9/4/25. Per the DON, it was important to give medications on time, especially medications like Rytary for Parkinsons Disease. The DON stated the facility had not given any of Resident 1's medications within the allowed timeframe. Per the DON, this could result in the symptoms of Parkinsons Disease worsening.Per a facility policy, dated 11/20/24 and titled Medication Administration and Storage, .Review and verify MD orders and follow 6 Rights of Medication Administration [right patient, right medication, right use, right dose, right time, right route].

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to implement a facility plan for a power outage and accurately report the unusual occurrence to the California Department of Public Health (CDPH).As a result, the facility was not prepared for a planned power outage, and 50 of 111 residents did not receive their medications in a timely manner.Cross reference: F755 Findings:A consumer complaint was filed with CDPH regarding a resident not receiving medications in a timely manner on 8/11/25 (Resident 1).A Facility Reported Incident (FRI) was filed with CDPH regarding a planned power outage which occurred on 8/11/25. The FRI indicated protocols were implemented, including the use of paper Medication Administration Records (MARs) for resident medication administration. According to the FRI, .No untoward incidents were noted.A concurrent interview and record review was conducted with the Director of Maintenance (DM) on 8/12/25 at 1:03 P.M. The DM stated the power outage on 8/11/25 was a planned power outage for a cable upgrade. The DM stated he had been notified by the power company approximately two weeks prior to the outage. Per the DM, he had texted the management team at the facility on 7/23/25 to let managers know the power outage would occur. The DM stated he should have reminded the managers several days before the power outage so they could implement their protocol. The DM stated his failure to inform the managers closer to the date may have resulted in the lack of preparation. The DM provided a text message, sent to department managers on 7/23/25. The text was addressed to the Administrator (Admin), Director of Nursing (DON), Medical Records Director (MRD)and approximately 20 others facility managers.An interview was conducted with Licensed Nurse (LN) 1 on 8/12/25 at 2:15 P.M. LN 1 stated she had worked the day the power outage occurred. LN 1 stated she was not aware the power was going to be out on 8/11/25, so she had to rely on paper records of the MAR. LN 1 stated the paper MARs were not available until approximately 10:30 A.M., then the power was back on. LN 1 stated she had administered medications late to most of her assigned residents.An interview was conducted with the Medical Records Director (MRD) on 8/12/25 at 3 P. M. The MRD stated she was surprised when the power went off on 8/11/25. The MRD stated she and another medical records staff member had gone to a sister facility and printed over a thousand MARs. The MRD stated they returned to the facility at about 11 A.M. and the power had been restored. The MRD stated if she knew in advance the power was going out, they would have printed the MARs the day before so the facility could be prepared, and so medications could be administered. An interview was conducted with the Social Services Director (SSD) on 8/12/25 at 3:15 P.M. The SSD stated she had met with Resident 1 and her family on 8/11/25 as the family had expressed concerns about the medications not being administered on time. The SSD stated the family was particularly concerned about the Parkinsons medication, which needed to be administered on time. The SSD stated Resident 1 was discharged with her family after she met with them, and partially due to the medication administration timing.An interview was conducted with the Assistant Director of Nursing (ADON) on 8/21/25 at 2:12 P.M. The ADON stated 50 of the 111 residents residing in the facility on 8/11/25 received their medications late.On 9/4/25 at 9:30 A.M., an interview was conducted with the Admin. The Admin stated on 8/11/25 she had arrived at the facility at approximately 9:30 A.M., and the front lobby and entrance to the building were dark. The Admin stated, I was surprised. The Admin stated the text sent by the DM was not the official way of communicating with the facility managers. The Admin stated the correct process was to send an email, or to speak directly with the Admin. Per the Admin, she did not recall seeing the text sent by the DM on 7/23/25, and other managers should have redirected the DM to the correct process, but nobody did. The Admin stated if the DM had communicated via email or in person, the facility would have planned appropriately to implement the emergency plan for power outages. The Admin stated, We would have planned differently. The letter to CDPH did not include the problems we experienced. I thought the physician's orders were paper MARs, I was wrong. We did not communicate well. We should have communicated with the team 72 hours before the planned outage to ensure we had everything ready. Per a facility policy, revised 7/2007 and titled Unusual Occurrence, It is the policy of this facility, that an unusual occurrence will be reported accurately and completely.