

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 09/16/2025
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)
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. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had access to care and services for two of two sampled residents reviewed for Resident Rights (Resident 1 and Resident 2), when: 1. The facility did not provide Resident 1 condom catheters (can be used by men to collect urine) and he had to purchase/ order for himself. 2. Resident 2 did not have access to television channels for activity. These failures had the potential not to meet Resident 1's needs and affect Resident 2's mental health that may affect their quality of life. Findings: 1. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder, the spinal cord and brain don't work the way they should, common example dribbling urine or incontinence), per the facility's admission Record. Resident 1's minimum data set (MDS, a federally mandated resident assessment tool), dated 9/4/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 15/15, which indicated Resident 1's cognition was intact. The functional abilities of the MDS indicated Resident 1 had impairment of both his upper and lower extremities. On 9/16/25 at 3:17 P.M., an observation and an interview were conducted with Resident 1 in his room. Resident 1 was sitting up in bed and was watching a television show. Resident 1 stated he had issues getting his packages and one of those packages contained condom catheters. Resident 1 stated They run out last week and I have to order for myself. Resident 1 stated he should not have been ordering for himself, and the facility should have provided him with his needs. Resident 1 stated, Isn't that my right? They should have available supplies for me. On 9/16/25 at 3:54 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 1 was very alert and oriented. CNA 2 stated Resident 1 placed orders online and expected them to be delivered to him when the package arrived. CNA 2 stated Resident 1 expressed not satisfied with their process. CNA 2 stated the facility run out of condom catheters for Resident 1 and he had to get condom catheters online for himself. CNA 2 stated since the facility had no supplies for Resident 1, she had to use the condom catheter Resident 1 purchased. CNA 2 stated there should have been supplies available for the residents to meet their needs. On 9/16/25 at 4:56 P.M., a joint interview was conducted with the Director of Staff Development (DSD) and the Director of Nursing (DON). The DSD stated Resident 1 was very alert and oriented. The DON stated the expectation was for the facility to provide supplies for the residents. The DON stated, For the condom catheter, he doesn't have to buy one. We have to make sure we have an available supply for the residents to meet their needs. A review of the facility's undated policy titled Resident Rights was conducted. The policy did not indicate accommodation of residents' rights and needs. 2. Resident 2 was admitted to the facility on [DATE], with diagnoses which included fracture of his ribs and cognitive communication deficit (are those in which a person has difficulty communicating because of injury to the brain), per the facility's admission Record. Resident 2's minimum data set (MDS, a federally mandated resident assessment tool), dated 9/11/25, Resident 2 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 13/15, which indicated Resident 2's cognition was intact. On 9/16/25 at 2:35 P.M., an observation of Resident 2 in his room and an interview was conducted with Resident 2 and a family member (FM) at bedside. Resident 2 laid in bed and the television (TV) was off. Resident 2's FM stated the TV did not work properly since it only had four channels and one of which was a foreign language. Resident 2's FM stated Resident 2 had been in his room for 12 days without entertainment. Resident 2's FM stated the issue was brought up and nothing had been done. Resident 2's FM stated Resident 2 did not want to join the group activities because it was loud. Resident 2's FM took the remote control from the bed and attempted to look for channels. There were four channels streamed on the TV, one in foreign language, one was news, one was classic show, and one was shopping channel. Resident 2's FM turned off the TV. Resident 2's FM stated Resident 2 just stayed in bed and had nothing to do. Resident 2 then closed his eyes. On 9/16/25 at 3:05 P.M., a joint observation of Resident 2's TV channels and an interview was conducted with the Maintenance Director (MaD). The MaD stated the facility was in the process of changing providers for the TV. The MaD stated sometimes the TV got high channels and sometimes got the low channels. The MaD stated the TV channels were not consistent, and some residents' TV only had four channels. The MaD stated that it was not a good experience for the residents having no entertainment. On 9/16/25 at 3:54 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 2 was very alert and oriented. CNA 2 stated Resident 2 was recently admitted to</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** Based on observation, interviews and record review, the facility failed to ensure safe and sanitary measures were met when a used urinal was on top of a resident's bedside table with food and cleaning supplies (Resident 2), for one of four residents reviewed for infection control. This failure had the potential for contamination of food and cleaning supplies and spread of infection to Resident 2 and his visitors. Findings: Resident 2 was admitted to the facility on [DATE], per the facility's admission Record. Resident 2's minimum data set (MDS, a federally mandated resident assessment tool), dated 9/11/25, Resident 2 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 13/15, which indicated Resident 2's cognition was intact. On 9/16/25 at 2:35 P.M., an observation of Resident 2 in his room and an interview was conducted with Resident 2 and a family member (FM) at bedside. Resident 2 laid in bed and a bedside table was on his right side of the bed. On top of the bedside table was a used urinal with some drops of urine at the handle and at the bottom, a plastic bag of chocolate candies and cookies, and a roll of paper towel. Resident 2's FM stated He used the urinal, they don't rinse it and they put in the table. That is where he eats because he prefers to eat here. Look there is the urinal with urine in the handle. Is not that an infection control issues? On 9/16/25 at 2:53 P. M., a joint observation of Resident 2's bedside table and an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated the used urinal should not be on top of the table for infection control. On 9/16/25 at 4:56 P.M., a joint interview with the Director of Staff Development (DSD) and the Director of Nursing (DON) was conducted. The DON stated the urinal should not be on the bedside table due to possible cross contamination for infection control. A review of the facility's policy titled Infection Control, revised 6/2025, indicated, It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Procedure, 1. Standard Precautions are infection prevention practices that apply to the care of all residents. they are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Standard Precautions include: Environmental cleaning and disinfection.</p>		