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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Mountain Rehabilitation & Healthcare Center	11895 Avenue of Industry San Diego, CA 92128

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and implement the care plan for one of three residents (Resident 1) reviewed for falls.As a result, Resident 1 continued to sustain additional falls and was placed at risk for injury.Findings:Per the facility's admission Record, Resident 1 was admitted to the skilled nursing facility on [DATE] and readmitted on [DATE] with diagnoses which included repeated falls, displaced fractures of the fifth and sixth cervical vertebrae (bones that form the spinal column) , and displaced intertrochanteric fracture of left femur (a broken hip).During a record review, the facility's Fall Risk Evaluation dated 1/3/26 indicated Resident 1 was at high risk for falls.During a review of Resident 1's Interdisciplinary Team (IDT- a group of professionals with different areas of expertise) progress note dated 1/5/26 at 13:41 P.M. the note indicated, IDT fall committee met today to discuss unwitnessed falls that happened on 1/2/26 at 1458 and 1/3/26 at 1412 with no injuries noted.UNWITNESS [sic] fall ON 1/2/26: Pt [Patient] is alert and oriented person only, not to situation, place or time. Pt [patient] is confused at all times.INTERVENTIONS: Landing matt [sic] was place [sic] at pt bedside on the floor.PSA [Pressure Sensitive Alarm- a device designed to trigger an alert when a patient attempts to leave a bed or chair.] on bed.Continue Neuro assessments.Continue to assess pt for pain. WITNESS FALL [sic] on 1/3/26: Per PM medication nurse, she was walking in the hallway and looked into pt room. Pt then noted to be sitting at the side of the bed and slid out of bed and landed on her buttock on the landing mat next to the pt bed.NEW INTERVENTIONS: Medication review.Move pt closer to nurses' station once bed becomes available.Frequent rounding by CNA and LN.Continue bed at lowest position and wheels lock [sic].Continue PSA.Frequent brief checks.Continue with landing matt [sic] at bedside. The IDT note indicated, ROOT CAUSE: Pt is impulsive and confused, restless and attempts to get out of bed frequently without using her call light.During a review of Resident 1's IDT note dated 1/30/26 at 08:54 A.M., the note indicated, IDT review and nursing follow up regarding resident fall incident dated on 01/28/26.At around 1710, a staff member was conducting a routine rounds and responding [sic] to a PSA going off. Staff entered the room and found the other resident [Resident 1] on the floor next to her bed.Continued close monitoring, redirection about safety and surroundings, and fall prevention interventions implemented to reduce risk of recurrence.During an interview with Licensed Nurse (LN) 2 on 3/20/26 at 9:50 A.M., LN 2 stated Resident 1 was not moved closer to the nurses station after the fall on 1/3/26. LN 2 stated, we prioritized other residents whose families requested a different room. LN 2 stated Resident 1 sustained additional falls on 1/28/26, and he did not see any new interventions implemented. LN 2 stated, we should have implemented [new interventions] LN 2 stated the purpose of updating the care plan is to prevent further falls. LN 2 stated, The goal is to make sure [Resident 1] doesn't fall again.During a telephone interview with the Director of Nursing (DON) on 4/16/26 at 3:31 P.M., the DON stated it was his expectation was for an updated plan of care after each fall. The DON stated it was important for Resident 1 to have a personalized plan of care updated to prevent future fall events from occurring.During a review of the facilty's policy titled Post Fall Assessment, revised 5/2025, the policy indicated, A care plan or an update to an existing care (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan will then be generated.Identify an action plan or approaches to be taken in an attempt to prevent further falls based on newly identified facts or risk factors.

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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 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 provide adequate monitoring following a change in condition for one of three residents (Resident 1) reviewed for falls.As a result, Resident 1 had the potential to have injuries related to the fall to go unnoticed, and to receive delayed care from staff.According to the facility's admission Record, Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included repeated falls, displaced fractures of the fifth and sixth cervical vertebrae (bones that form the spinal column), and displaced intertrochanteric fracture of left femur (a broken hip).A record review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool) dated 1/7/26 indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition, or thinking skills) of 7, which indicated severe cognitive impairment. The MDS further indicated Resident 1 had two or more falls prior to admission to the facility. Resident 1 required assistance with transfers Activities of Daily Living (ADL's- activities such as eating, dressing, and bathing) and was assessed as a high fall risk upon admission.During a record review, Resident 1's History and Physical examination by the facility Medical Director (MD) dated 3/9/26 indicated, Recurrent falls, hospice focused treatment. The H&P further indicated Resident 1, Does NOT HAVE capacity to make own decisions [sic].During an interview with Resident 1 on 3/20/26 at 9:37 A.M., Resident 1 stated, I broke my neck then I broke my leg. I fell but I don't know how. My knee came out from underneath me and BOOM that was it.During an telephone interview with Resident 1's Responsible Party (RP) 1 on 3/20/26 at 11:08 A.M., RP 1 stated Resident 1 had fallen multiple times at the facility since being admitted on [DATE]. RP 1 stated she was notified by the facility on 3/3/26 that Resident 1 was sent to the hospital for severe hip pain, due to an unwitnessed fall that occurred on 3/2/26.During an interview with Licensed Nurse (LN) 3 on 3/20/26 at 4:36 P.M., LN 3 stated she was the unit charge nurse on 3/2/26, PM shift. LN 3 stated after an unwitnessed fall, nursing would assess the resident for any injuries and start a neuro checks (an assessment consisting of vital signs, movements, and level of consciousness designed to detect any changes in neurological status). LN 3 stated neurochecks were done at specific time intervals for 48 hours after an unwitnessed fall. LN 3 stated neurochecks were important because there may be delayed effects following a fall. LN 3 stated on 3/2/26, NOC shift was not aware that Resident 1 had sustained a fall on the previous (PM) shift, and neurochecks were not conducted for Resident 1.During a telephone interview with Certified Nursing Assistant (CNA) 1 on 3/24/26 at 2:36 P.M., CNA 1 stated he was Resident 1's assigned CNA on 3/2/26. 1 stated he was passing by Resident 1's bedroom and heard an alarm going off. CNA 1 stated he observed Resident 1 laying on the floor, next to her bed. Per CNA 1, he alerted Licensed Nurse (LN) 4 and they assisted Resident 1 back to bed. CNA 1 stated he checked Resident 1's vital signs three times before his shift was done. During a telephone interview with Licensed Nurse (LN) 5 on 3/24/26 at 2:48 P.M., LN 5 stated she was the charge nurse for the night shift on 3/2/26 to 3/3/26. LN 5 stated on 3/3/26 around 6:50 A.M., Resident 1's CNA informed her that Resident 1 had a lot of pain, was crying out and screaming during diaper change. It wasn't her baseline. LN 5 stated she assessed Resident 1 and, I noticed a difference in length in her legs. LN 5 stated she was not aware that Resident 1 had a fall on 3/2/25. LN 5 stated no neuro checks were performed for Resident 1 because NOC shift was not notified that Resident 1 had a fall. LN 5 stated neuro checks were important to ensure Resident 1's safety. LN 5 stated, neuro checks are important, especially if the fall was unwitnessed. We don't know if there is an injury that appears. There could be delayed symptoms not picked up by the staff immediately upon the fall.Licensed Nurse (LN) 4 was unavailable for an interview.A review of a document titled Neurological Assessment was conducted. The document indicated, FREQUENCY.Q [every] 15 Mins [minutes] x 4 = 1 [hour].Q 30 Mins x4 = 2 [hours].Q hour x 5= 5 [hours].Q 4 hours x4= 16 [hours].Q Shift x 6 =48 [hours] The document indicated Resident 1's neurological assessment was completed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/2/26 at 2215 (10:15 P.M.), 3/2/26 at 2230 (10:30 P.M.), AND 2245 (10:45 P.M.). There was no further neurological assessment completed.On 3/27/26 at 10:51 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the purpose of neurochecks was to determine injury to the head, because we don't know, even if the resident says they didn't hit their head we still need to act with caution, we do it to spot deficits that are occurring.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement fall preventative measures recommended by the Fall IDT (Interdisciplinary Team- a group of individuals with different areas of expertise) for one of three residents (1) who was assessed as a high fall risk with a history of multiple falls. As a result, Resident 1 experienced additional falls on 3/2/26 which resulted in hospitalization and surgery for a fractured (broken) hip. Findings:A review of the undated admission Record indicated, Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included repeated falls prior to admission at the facility and displaced fractures of the fifth and sixth cervical vertebrae (bones that form the spinal column), and displaced intertrochanteric fracture of left femur (a broken hip). A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), dated 1/7/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition, or thinking skills) of 7, which indicated severe cognitive impairment. The same MDS assessment indicated Resident 1 had two or more falls prior to admission to the facility. According to section GG of the MDS, which indicated functional status, Resident 1 required assistance with transfers and activities of daily living (ADL's- activities such as eating, dressing, and bathing). Resident 1 was assessed with a fall risk score of 13, which indicated Resident 1 was at risk for falls. A review of Resident 1's History and Physical (H&P) examination, dated 3/9/26, conducted by the facility Medical Director (MD) indicated, Recurrent falls [prior to and during admission to the facility], hospice (specialized care for individuals who are near the end of life) focused treatment. The H&P further indicated Resident 1, Does NOT HAVE capacity to make own decisions [sic]. During a concurrent interview and document review with Licensed Nurse (LN) 2 on 3/20/26 at 8:20 A.M., LN 2 stated Resident 1 had sustained five falls at the facility since admission on [DATE]. LN 2 stated Resident 1 had falls on the following dates: Fall #1: According to the Fall Committee IDT note dated 1/5/26 at 13:41 (1:41 P.M.), on 1/2/26 at 2:58 P.M., a medication nurse was walking by Resident 1's bedroom and observed Resident 1 lying on the floor. New interventions initiated: 1) Landing mat (a cushioned pad designed to absorb impact and reduce the risk of injury) at Resident 1's bedside. 2) Provide a pressure sensitive alarm (PSA- a device designed to trigger an alert when a patient attempts to leave a bed or chair). The fall risk score 9, on 1/2/26, which indicated high fall risk, on 1/2/26. Fall #2: Resident 1 had a witnessed fall on the PM shift on 1/3/26. According to the Fall Committee IDT note dated 1/5/26 at 13:41 (1:41 P.M.), a staff member witnessed Resident 1 sliding out of her bed and landing in a sitting position on the landing mat, on the floor. Resident 1 was unable to state what she was trying to do. Per the IDT note, Resident 1's call light was within reach. New interventions included a medication review and moving Resident 1 closer to the nurse's station once a bed became available. However, LN 2 stated a bed was not available. The IDT note indicated, ROOT CAUSE: Pt is impulsive and confused, restless and attempts to get out of bed frequently without using her call light. Fall #3: Resident 1 sustained an unwitnessed fall on the PM shift on 1/28/26. According to the Fall Committee IDT note dated 1/20/26, a staff member was conducting rounds and heard the pressure sensitive alarm activated. The staff member found Resident 1 sitting on the floor next to her bed. No new personalized fall interventions were implemented after this fall. Fall #4: Resident 1 sustained an unwitnessed fall on the PM shift on 3/2/26. According to the Fall Committee IDT note dated 3/4/26 at 13:13 (1:13 P.M.), around 10 P.M., Resident 1's assigned, Certified Nursing Assistant (CNA) 3, found Resident 1 lying on the floor next to her bed after hearing the pressure sensitive alarm activated. The IDT note indicated, immediate assessment was completed by medication nurse and Resident 1 was placed back in bed. The IDT note further indicated at 6 A.M., while receiving care, the CNA reported the resident complaining of severe pain during brief change. The Charge Nurse assessed the resident. The assessment revealed the left (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lower extremity was internally rotated, suspicious for hip injury. Resident 1 was transported via 911 to [Acute Care Hospital Name]. Per hospital nurse, resident admitted with diagnosis of status post fall with left hip fracture. Surgical intervention pending. Fall #5: Resident 1 sustained an unwitnessed fall during the PM shift on 3/17/26. According to the Fall Committee IDT note dated 3/19/26 at 12:38 P.M., Resident 1 sustained a fifth fall on 3/17/26 at approximately 9:30 P.M. A staff member heard Resident 1's pressure sensitive alarm and found Resident 1 sitting on the floor next to her bed. Resident 1 was assisted back to bed and currently placed in a room closer to the nurse's station to allow for closer monitoring. During a follow up interview with LN 2 on 3/20/26 at 8:40 A.M., LN 2 stated after Resident 1's second fall, one of the interventions was to move Resident 1 closer to the nurse's station, when one became available. LN 2 stated Resident 1 was never moved until after the fourth fall on 3/2/26, after which she sustained a left hip fracture. LN 2 stated rooms were available, but we prioritized other residents whose family members requested a different room. LN 2 stated moving Resident 1 closer to the nurse's station after her second fall could have prevented her from having additional falls, which could have prevented the left hip fracture. A record review of Resident 1's recent transfer documents titled Medical Record Progress Notes, dated 11/4/25 indicated Resident 1 had a history of recurrent falls prior to her admission to the facility, which had resulted in C5 and C6 (bones in the lower neck) fractures. A review of Resident 1's Emergency Department Physician's Notes, dated 3/3/26 at 8:59 A.M. indicated, [AGE] year-old female from [Skilled Nursing Facility] presented with left hip pain. Patient reportedly had a fall yesterday night [on 3/2/26] out of her bed. Has a history of frequent falls. At that time was put back in bed by [PM shift] staff but no one was told about the fall. This morning, they [NOC shift staff] noticed she had left hip pain [during care]. Pain is worse with movement. Patient is normally nonambulatory but does fall frequently. A review of Resident 1's hospital record dated 3/3/26 at 5:27 P.M., indicated, Although [Resident 1] is nonambulatory, displaced intertrochanteric femur fractures [broken hip] can be particularly painful with repositioning.I discussed that surgery is associated with risks including risk of nonunion or malunion, hardware failure, pain, wound healing problems, infection, blood loss, as well as risks of anesthesia including heart attack, stroke, and death in rare cases. Understanding these risk [sic], the patient's sister and medical decision maker elected to proceed with surgery for the purpose of mitigating pain with repositioning and laying in bed. Resident 1's hospital record dated 3/4/26 at 3:17 A.M. was reviewed. The document titled, Operative Reports indicated, [Resident 1] is a 70 Years Female [sic] who sustained a left intertrochanteric hip fracture as a result of an unwitnessed fall from bed.discussed with the patient's sister that although she is not ambulatory, a displaced intertrochanteric femur fracture [a broken hip] is generally painful even when laying in bed or sitting in a chair.fracture fixation can be considered for comfort and ease of positioning. During a review of Resident 1's IDT note dated 3/4/26 at 13:13 indicated, IDT review and nursing follow up regarding resident's fall incident. On 03/02/26, the resident was last seen at start of shift resting in bed.Per CNA resident was last seen in bed after completion of patient care at approximately 21:30. At approximately 22:00, CNA stated that upon hearing the bed alarm, he responded immediately and found resident lying on the floor next to the bed.At approximately 0600 on 03/03/26, CNA reported resident complaining of severe pain during brief change.Charge Nurse assessed resident. Assessment revealed left lower extremity internally rotated, suspicious for hip injury. Resident verbalized significant pain.Resident transported via 911 to [Acute Care Hospital]. Follow up call placed to hospital at approximately 1200. Per hospital nurse, resident admitted with diagnosis of status post fall with left hip fracture. During a review of Resident 1's Fall Committee IDT note dated 03/19/26 at 12:38 P.M., the note indicated, IDT review and nursing follow up regarding resident's fall incident on 03/17/26. Resident was last seen at approximately 20:15 by LN [Licensed Nurse] .At approximately 20:30, bed alarm was heard. Nursing staff responded immediately and found resident sitting on the right side of the bed [on the floor] with back leaning against bed. During an interview with CNA 1 on 3/20/26 at 10:30 A.M., CNA 1 stated she was Resident 1's assigned CNA. Resident 1 had multiple (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	falls at the facility. CNA 1 stated Resident 1 was confused, never used her call light, and had a behavior of always trying to get out of bed without calling for assistance. CNA 1 stated she assisted Resident 1 in her wheelchair before breakfast (approximately 7:30 A.M.) and kept her up in the wheelchair until after lunch to prevent her from trying to get out of bed. During a concurrent interview and record review with LN 1 on 3/20/26 at 3:26 P.M., LN 1 stated Resident 1 returned from the hospital on 3/8/26 after sustaining a left hip fracture. LN 1 stated Resident 1 was moved closer to the nurse's station upon return. LN 1 stated Resident 1's previous bedroom was farther away from the nurse's station, in a B bed, that was not as visible from the hallway. LN 1 further stated Resident 1 continued to attempt to get up and walk without assistance. On 3/27/26 at 10:51 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the intervention to move Resident 1 closer to the nurse's station was intended to provide closer proximity for staff, allowing for quicker visualization if her bed alarm activated. The DON further stated there would have been more eyes on [Resident 1]. The DON acknowledged that while the IDT recommendation on 1/5/26 included moving Resident 1 closer to the nurse's station due to a fall incident on 1/3/26 (2nd fall), this was not implemented until 3/8/26, following Resident 1's 4th fall incident that resulted in a hip fracture. The DON stated it was his expectation that the recommended fall preventative measures be implemented. During a record review, the facility's policy titled Fall Assessment, Post, revised 5/2025, indicated, Identify an action plan or approaches to be taken in an attempt to prevent further falls.Document.that the care plan was updated to reflect new action plan or approaches for prevention of falls.