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	04/24/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to meet resident needs in a timely manner for four of four residents (Residents 214, 17, 104, and 317), reviewed for accommodation of needs and one confidential resident (CR 1) when: 1. Resident 214, 17 and 104 experienced a delay for staff to provide personal care; and, 2. Resident 317 and CR 1 did not receive their meals in a timely manner. These failures had the potential for residents to feel not dignified and not valued. Findings: 1a. Resident 214 was admitted to the facility on [DATE], with diagnoses which included orthopedic aftercare related to cervical disc disorder (area of the neck) at cervical level 4 and 5, per the facility's Admission Record. An observation and interview was conducted with Resident 214 during initial tour on 4/21/25 at 8:08 A.M. Resident 214 was sitting up in bed with a gown on. Resident 214 stated he asked to be changed over one hour ago. Resident 214 stated someone came into his room, turned off his call light, and said they would be right back. Resident 214 stated he still needed to be changed and no one had helped him. Resident 214 activated his call light again, to notify staff he still needed assistance. An observation and interview was conducted with Resident 214 in his room on 4/21/25 at 8:33 A.M. Resident 214 stated his call light was turned off again by staff. Resident 214 stated a lady came in and said she would be right back, but no one had come back and he was getting tired of waiting. Resident 214 re-activated his call light for a third time. An observation was conducted outside Resident 214's room on 4/21/25 at 8:37 A.M. An unidentified female entered Resident 214's room, de-activated the call light and exited the room. An interview was conducted with Resident 214 in his room on 4/21/25 at 8:52 A.M. Resident 214 stated, Yes, they just finished changing me. When I asked what took so long, the male nurse (later identified as certified nursing assistant 12 [CNA 12}), told him, Breakfast always comes first. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with CNA 12 on 4/21/25 at 8:58 A.M. CNA 12 stated all resident call lights should remain on until their needs were met. CNA 12 stated he did not initially know Resident 214 needed to be changed, because no one had informed him. CNA 12 stated he was told all residents within the same room had to finish eating their meals first before anyone could be changed, so they were not bothered by any odors. An interview was conducted with Resident 214 on 4/22/25 at 8:40 A.M., in his room. Resident 214 stated, They told me I'm getting red in the groin area from urinating too much. I call them when I need to be changed, but it takes them forever to change me. I would like to be out of these depends, (incontinence pads) and urinate on my own. Resident 214's medial record was reviewed on 4/22/25. According to the Minimum Data Set (a clinical assessment tool), dated 4/22/25, Resident 214 had a cognitive score of 13, indicating cognition was intact. According to the facility's care plan, titled ADL (activities of daily living-such as dressing, toiletry, and eating) revised 4/21/25, interventions listed included: Encourage to use call bell for assistance. Personal Hygiene: Requires staff participation. An interview was conducted with the Treatment nurse (Tx LN) on 4/23/25 at 10:23 A.M. The Tx LN stated call lights should always stay on until the residents' needs were met. An interview was conducted with Licensed Nurse 11 (LN 11) on 4/23/25 at 10:26 A.M. LN 11 stated call lights should never be turned off until the residents' needs were met. LN 11 stated it was not a facility policy to wait for all the residents in the room to finish eating, until a resident could be changed. LN 11 stated waiting five minutes to be changed was acceptable, waiting 30 minutes was not, because it put residents at a higher risk of skin irritation. An interview was conducted with the Director of Staff Development (DSD) on 4/23/25 at 10:52 A.M. The DSD stated call lights should be answered within two to three minutes. The DSD stated it did not matter if roommates were still eating to change someone. The DSD stated changing and providing personal care was important for dignity and to prevent skin issues. The DSD provided copies of in-services related to call light response, dated 3/24/25, with 25 CNAs in attendance and 12 licensed nurses. Areas reviewed on the service were, .Do not answer call light and then turn off, and tell the patient/resident/family member you will be back . An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 4/24/25 at 8:54 A.M. The MDSN stated when a resident was admitted , the facility tracked and charted the residents' bladder and bowel control for five days, to determine if the resident could void on their own or if they required a toileting program. The MDSN reviewed Resident 214's toileting assessment, stating she evaluated him yesterday (seven days after admission) and determined he could urinate on his own and was capable of using a bedside commode with staff assistance getting up, out of bed. The MDSN stated if residents were able to void on their own, it was important to let them, for independence and dignity. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated she expected all call lights to be answered in a timely manner, to meet the residents' needs. The DON stated call lights should never be turn off if the resident's needs were not met. According to the facility's policy, titled Accommodation of Needs, undated, .Examples of Accommodation of Needs but is not limited to the following: .Call lights . According to the facility's policy titled Incontinence Care, undated, .this facility will provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff providing incontinence care will do so while maintaining dignity of the resident . According to the facility's policy, titled Call Light/Bell, undated, .1. Answer light/bell within a reasonable time . 38512 1b. Resident 17 was admitted to the facility on [DATE] with diagnoses to include dependence on a ventilator (a machine used to support or replace the breathing of a person who is ill), per the facility Admission Record. A record review was conducted. Per the 3/4/25 MDS, Resident 17 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS indicated Resident 17 required full staff assist for toileting, bathing, dressing, personal hygiene, and turning in bed. An interview was conducted with Resident 17 on 4/21/25 at 11:01 A.M. Resident 17 stated when she used her call light to get help, the CNAs come in to help her, At their convenience. Resident 17 stated she had anxiety, and waiting too long for help made her anxiety worse. An interview was conducted with the DON on 4/24/25 at 12:46 P.M. Per the DON, her expectation was for all staff to answer call lights as soon as possible. The DON stated it was important to answer call lights promptly to prevent skin problems, and to keep residents safe. According to the facility's policy, titled Accommodation of Needs, undated, .Examples of Accommodation of Needs but is not limited to the following: .Call lights . According to the facility's policy titled Incontinence Care, undated, .this facility will provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff providing incontinence care will do so while maintaining dignity of the resident . According to the facility's policy, titled Call Light/Bell, undated, .1. Answer light/bell within a reasonable time . 40610 1c. Resident 104 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, per the facility's Admission Record. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 104's record was reviewed. Resident 104's record titled, History and Physical, dated 3/7/25, indicated Resident 104 had the capacity to make own decisions. Resident 104's MDS record, dated 3/13/25, indicated Resident 104's BIMS score was 15/15 which suggested the resident was cognitively intact. Per the MDS, Resident 104's functional abilities indicated Resident 104 required maximal assistance on transferring to the toilet. On 4/23/25 at 8:47 A.M., an observation and an interview of Resident 104 was conducted in his room. Resident 104 was eating breakfast. Resident 104 stated he waited 33 minutes for his call light to be answered in the morning of 4/23/25. Resident 104 stated he checked the time when he hit the call button. Resident 104 stated he needed to use the bathroom. Resident 104 stated, I just needed them (staff) to place my wheelchair next to my bed so I can slide myself. It doesn't matter what I need, I could be either asking them to help me prepare for me to go to the therapy, I could ask them to close the door or the curtain because I cannot sleep if there is too much lighting. It happens anytime of the day. I think they are short staffed. Resident 104 further stated, Sometimes, they answer, they will say I'm helping another resident, and they don't come back or if they come back, they come back in two hours. On 4/23/25 at 9:31 A.M., an interview was conducted with CNA 21. CNA 21 stated Resident 104 was cognitively intact and knew what was going on. CNA 21 stated Resident 104 required assistance transferring from the bed to the wheelchair. On 4/24/25 at 10:38 A.M., an interview was conducted with the DON. The DON stated the expectation was that residents' needs should have been met and call lights should have been answered timely because that was their right and for resident's safety. According to the facility's policy, titled Accommodation of Needs, undated, .Examples of Accommodation of Needs but is not limited to the following: .Call lights . According to the facility's policy titled Incontinence Care, undated, .this facility will provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff providing incontinence care will do so while maintaining dignity of the resident . According to the facility's policy, titled Call Light/Bell, undated, .1. Answer light/bell within a reasonable time . 49330 2a. On 4/21/25 at 8:06 A.M., an observation was conducted in the hallway on one of the facility's units. A cart containing breakfast trays for residents on the unit was brought out by kitchen staff and left in the hallway. On 4/21/25 at 8:39 A.M., an observation was conducted at the meal cart. CNA 31 and CNA 32 began passing out the meal trays to approximately 25 residents on the unit. On 4/21/25 at 3:25 P.M., an interview was conducted with Resident 317. Resident 317 stated, This morning I just ate my cereal. I didn't eat the eggs because they were ice cold. The trays are always cold. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. During a Resident Council Meeting conducted on 4/22/25 at 10:20 A.M., CR 1 stated, .some days it takes a while for staff to bring the meal trays out .A.M. shift has so much to do that they can't get the food out on time . CR 1 stated his meal tray was often cold when it was delivered by staff. On 4/24/25 at 1:45 P.M., an interview was conducted with the DON. The DON stated it was her expectation staff distribute meal trays to residents as soon as the cart was delivered to the unit. The DON stated, They should have immediately passed out the trays, or at least communicated that the carts were out. We don't want the residents to have cold food. During a review of an undated policy titled Resident's Rights, Accommodation of Needs, the policy indicated, .It is the policy of this facility to provide accommodation of reasonable needs to the residents while in the facility, Procedures: Staff will review resident's preference and accommodate their needs .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to provide showers consistently for one of one sampled resident (Resident 24), reviewed for choices related to personal care. As a result, Resident 214's preferences and choices were not honored and respected. Findings: Resident 24 was readmitted to the facility on [DATE] with diagnoses which included muscle weakness, per the facility's Admission Record. Resident 24's history and physical, dated 3/31/25, indicated Resident 24 had the capacity to understand and make decisions. A record review was conducted of Resident 24. Resident 24's minimum data set (MDS - a federally mandated resident assessment tool), dated 4/1/25, indicated Resident 24's brief interview for mental status (BIMS, ability to recall) score was 15/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact). On 4/21/25 at 9:39 A.M., an observation and an interview of Resident 24 was conducted in her room. Resident 24 was sitting up in bed. Resident 24 stated she did not get a shower. Resident 24 stated no staff had offered her a shower. Resident 24 stated, If they (staff) miss it, I will have my shower the next week. I am not comfortable with it. I think they are understaffed. A review of Resident 24's shower sheets indicated, Resident 24 had received two showers in a three week time period, between 3/29/25 to 4/21/25. On 4/23/25 at 9:49 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 32. CNA 32 stated Resident 24 was very alert and oriented and required some help when receiving showers. CNA 32 stated Resident 24 had showers on Mondays and Thursdays. On 4/23/25 at 11:35 A.M., a joint review of Resident 24's clinical record and an interview was conducted with Licensed Nurse (LN) 21. LN 21 stated Resident 24's record indicated, she received two showers from 3/29/25 to 4/23/25. LN 21 stated the residents should not be missing their showers. LN 21 stated it was important to provide showers twice weekly for the residents' hygiene and comfort. On 4/24/25 at 10:38 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was to provide the residents showers. The DON stated staff should accommodate resident's needs for hygiene and promote dignity. A review of the facility's undated policy titled, Resident Rights, Accommodation of Needs, indicated, Policy: It is the policy of this facility to provide accommodation of reasonable needs to the residents while in the facility, Procedures: Staff will review resident's preference and accommodate their needs .Examples of Accommodation of needs but is not limited to the following .Showers . (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy, titled ADL (Activities of Daily Living), Services to carry out, indicated, Policy: It is the policy of this facility that residents are given the appropriate .services .Procedures .2. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services to maintain .personal hygiene .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 38512 Based on observation and interview, the facility failed to ensure a clean, safe and comfortable homelike environment when: 1. An observation of 11 of 24 resident areas in one nursing unit had dirty wall-mounted fans in their rooms, and 2. An observation of 13 of 24 resident areas in one nursing unit had broken furniture, holes in the wall, and/or scraped paint areas in their rooms. These failures had the potential to negatively impact the residents' health and well-being. Findings: On 4/21/25 starting at 8 A.M., observations of all resident rooms on one nursing unit was conducted. Nine of 11 residents were unable to speak and had no visitors present. An observation of 11 of 11 residents who were on ventilators (a mechanical device that helped a person breathe when they cannot do so on their own) was conducted. 1. Each of the 24 resident areas had a 12- inch fan mounted to the wall directly across from, and facing the resident's head of bed. An observation of 11 of the fans had a black coating of what appeared to be fine dirt and residue adhering to each fan blade. 2a. Ten of 24 resident areas had shelving units next to their beds with exposed, unfinished wood visible along the front surfaces. 2b. Two of 24 resident areas had paint scraped off the walls in large sections, approximately 4 inches wide by 8 inches long. The scraped walls were near the head of the bed but visible from the doorway. 2c. One of 24 resident areas had what appeared to be several strips of two- inch wide, gray duct tape covering the bathroom door latch plate. 2d. One of 24 resident areas had what appeared to be a repaired hole in the wall approximately one foot inside of the room, near the thermostat at eye level. The hole had been filled with a white, bumpy filler, not sanded flat and not painted to match the greenish-brown wall color. 2e. Two of 24 resident areas had a long, coiled orange extension cord extending from the hallway outside the room into the room where it was plugged in. The extension cord was piled up against the resident's room wall and visible to anyone entering the room. Approximately one foot of the cord formed a loop which extended into the room walkway. 2f. Six of 24 resident areas had closet doors or drawers that extended out and were open, and would not close. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 10 A.M., a concurrent interview and record review was conducted with Nurse Manager (NM) 1. NM 1 stated housekeeping cleaned rooms daily, including all furniture and the outside of the fans. NM 1 stated she rounded daily on each room and was responsible for reporting any broken or damaged equipment and supplies. NM 1 stated any broken items would be documented in the maintenance log, then the maintenance workers would review the log and make the repairs. The maintenance log was reviewed for the previous two months, no broken furniture or dirty equipment was documented. NM 1 stated it was important to maintain the resident rooms to create a homelike environment. On 4/23/25 at 11 A.M. a concurrent observation of resident rooms, and interview with the Director of Maintenance (DM) and Administrator (ADM 2) was conducted. All resident rooms with concerns were viewed. The DM stated since fans were electrical, his department was responsible for cleaning the fans. The DM stated he rounded each day but relied on staff to communicate items that needed repair. The DM stated staff can either write down the items in the maintenance log, which he checked daily, or call him directly. The DM stated he did not recall anyone from the nursing unit calling him in regards to the fans or the damage in the rooms. The DM stated it did not give a good impression to residents or visitors if the rooms and equipment were dirty or damaged. ADM 2 stated the nursing unit was starting a rounding program to identify the problem areas. On 4/24/25 at 12:54 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated all furniture in the resident rooms should be intact, and all fans clean. The DON stated it was her expectation that all staff going into rooms would report items needing repair and inform the appropriate staff, including the NM. Per the DON, We try to provide a homelike environment for all residents. We missed some things because the DM is new, but that is no excuse. Per a facility policy, revised May 2007 and titled Housekeeping, It is the policy of this facility to provide a clean, comfortable, homelike and sanitary living area . Per an undated facility policy, titled Resident Rights, .Safe Environment. You have a right to a safe, clean, comfortable and homelike environment .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to develop and implement individual care plans for two of five resident's (Resident 214 and Resident 220), reviewed for care plans. This failure resulted in Resident 214 experiencing pain, when a care plan was not developed for constipation and Resident 220's plan of care was not implemented as ordered by the physician, to wear bilateral foam boots (both feet), to protect and prevent future skin injuries to the heels. Findings: 1. Resident 214 was admitted to the facility on [DATE], with diagnoses which included orthopedic aftercare related to cervical disc disorder (neck region), per the facility's Admission Record. An observation and interview was conducted with Resident 214 on 4/22/25 at 8:41 A.M., as he laid in bed. Resident 214 was rubbing his abdomen, stating he felt discomfort and bloating. Resident 214 stated he had not had a bowel movement in several days and they gave him a suppository last night, but nothing has happened yet. A follow up observation and interview was conducted with Resident 214 in his room on 4/23/25 at 7:59 A.M. Resident 214 stated the staff had given him an additional suppository last night, but still nothing had happened. Resident 214 stated he felt bloated and uncomfortable, and he did not know how much longer he could go on like this. Resident 214's clinical record was reviewed on 4/23/25. According to the facility's Task Documentation, Resident 214 had not had a bowel movement since his admission on 4/17/25 (six days). According to the physician's order, dated 4/17/25: - Docusate Sodium oral liquid (Dulcolax-a stool softener) two times a day for bowel movement. - Lactulose oral solution (use to treat constipation) twice a day for constipation. - Lactulose oral solution every 24 hours as needed for bowel care if no bowel movement in three days. - Mineral oil enema if not relieved by Dulcolax or Lactulose. The Medication Administration Record (MAR) was reviewed for April 4/17/25 through 4/22/25. - Dulcolax and Lactulose oral liquid had been administered twice a day as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lactulose every 24 hours if no bowel movement in three days was never administered. - Mineral enema had not been administered as ordered, .if not relieved by Dulcolax or lactulose. An interview and record review was conducted with Licensed Nurse 11 (LN 11) on 4/23/25 at 10:26 A.M. LN 11 stated the facility's bowel protocol after three days and no bowel movement was to follow the physician's order. LN 11 reviewed Resident 114's MAR and stated he was a high risk for constipation because of his pain medication and lack of mobility. LN 11 could not locate any documented evidence a care plan had been developed for Resident 214 related to constipation. An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 4/24/25 at 8:54 A.M. regarding Resident 214. The MDSN stated care plan were important as a communication tool for nurses, so interventions were applied consistently. The MDSN stated Resident 214 should have had a care plan developed for constipation on admission, since he was considered high risk. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated care plans were important for baseline data, in order to recognize when residents were improving or deteriorating. The DON stated care plans were a tool for communication among staff, so interventions could be applied consistently. The DON stated Resident 214 should have had a constipation care plan developed upon admission, since he was considered a high risk, due to pain medication being administered. The DON stated since a care plan was not developed and his bowel movements were not communicated, he could have experienced unnecessary discomfort. The facility's policy, titled, Bowel Care Management, undated, did not address care planning related to constipation. 2. Resident 220 was admitted to the facility on [DATE] with diagnoses which included displaced fracture of the right tibia (lower leg bone) and right patella (knee), per the facility's Admission Record. An observation and interview was conducted with Resident 220 on 4/21/25 at 9:23 A.M. Resident 220 was sitting up in bed with a sling and partial splint on her left forearm. Resident 220 stated she fell four days ago, while using the bedside commode, resulting in a fractured left wrist. On 4/22/25, Resident 220's clinical record was reviewed. According to the physician's order, dated 4/8/25, a knee immobilizer (splint for support) was needed when resident was out of bed. According to the facility Fall Risk Evaluation, dated 4/8/25, Resident 220 scored as a high risk for future falls. According to the care plan, titled High Risk of Falls related to Weakness, impaired mobility, dated 4/8/25, no intervention was listed for knee immobilizer to be applied when out of bed as ordered by the physician. (continued on next page)

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	04/24/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's Change of Condition Evaluation, dated 4/16/25, Resident 220 was found sitting on the floor with obvious deformity noted to the left wrist. Resident 220 stated she was sitting on the bedside commode then stood up to use the walker, and the commode shifted behind her, resulting in a fall. An interview was conducted with Certified Nursing Assistant 11 (CNA 11) on 4/22/25 at 9:46 A.M. CNA 11 stated she assisted Resident 220 to the bedside commode and then waiting outside. CNA 11 stated she did not apply Resident 220's knee immobilizer at the time of transfer. CNA 11 stated she was outside of Resident 220's room for about ten minutes and was informed by other staff that Resident 220 fell . An interview and record review was conducted with the Treatment licensed Nurse (Tx LN) on 4/23/25 at 10:23 A.M. The Tx LN stated Resident 220 was identified as a high fall risk since she had fractures to her right leg and knee. The Tx LN stated if the physician ordered her knee immobilizer to be worn when out of bed, it should have been applied. The Tx LN stated the knee immobilizer acted as a stabilizer, and it was included in the physician's plan of care. The Tx LN stated she would not have gotten Resident 220 up, without the knee immobilizer in place. An interview was conducted with Licensed Nurse 11 (LN 11) on 4/23/25 10:27 A.M. LN 11 stated Resident 220's had a physician's order, which indicated the resident should have her knee immobilizer on whenever she was out of bed. LN 11 stated this was the physician's plan of care and it should have been implemented. LN 11 when a resident used a bedside commode, it was considered out of bed, so the immobilizer should have been put on. An interview was conducted the Director of Staff Development (DSD) on 4/23/25 at 10:52 A.M. The DSD stated Resident 220's knee immobilizer should have been put on before the resident got out of bed, to use the bedside commode. The DSD stated the physician ordered the immobilizer to support and stabilize the right leg, and the plan of care should have been implemented. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated Resident 220 was a high fall risk and the CNA should have applied the leg/knee splint before she was assisted out of bed. The DON stated the physician's plan of care was not implemented. According to the facility's policy, titled Fall Management System, undated, .2. Residents with Fall Risk Assessments score of 11-16 or above are considered high risk and will have an individualized care plan develop[ed that included measurable objective and timeframe's. The care plan interventions will be developed to prevent falls and will consider the elements of assessment that put the resident at risk .

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	555326	A. Building B. Wing	04/24/2025

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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** 40610 Based on interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 97), reviewed for closed record, when: 1. Staff failed to follow physician's order related to intravenous (IV, within a vein) antibiotics (anti-infective medications) therapy for Resident 97, and, 2. Consistently provide Resident 97's peripherally inserted central catheter (PICC, a long, thin tube inserted through a vein in the arm) care. These failures placed Resident 97 at risk for delayed healing and PICC line associated complications. Findings: Resident 97 was readmitted to the facility on [DATE] with diagnoses which included sepsis (a life-threatening blood infection), and urinary tract infection (UTI), per the facility's Admission Record. A review of Resident 97's clinical record was conducted. Resident 97's physician's order dated 4/1/25, indicated, Resident 97 was to receive two antibiotic medications and PICC line care. The physician's orders were as follows: - Ertapenem to be given through IV one time a day for 14 days. - Merrem to be given through IV three times a day (schedule was 6 A.M., 2 P.M., and 10 P.M.) until 4/4/25. - Flush the PICC line before and after each antibiotic dose. A review of Resident 97's IV medication administration record (MAR) was conducted. Resident 97's IV MAR for April 2025 indicated, the License Nurses (LNs) missed medication documentation for : - Ertapenem from 4/2/25, 4/3/25 and 4/4/25. - Merrem two times of ten opportunities. - PICC line care three times of 12 opportunities. On 4/24/25 at 9:16 A.M., a joint review of Resident 97's clinical record and an interview was conducted with Licensed Nurse (LN) 22. LN 22 stated Resident 97 was to get two antibiotic medications from 4/1/25 for infections. LN 22 stated there were missed entries for medication administration of Ertapenem for Resident 97 from 4/2/25 through 4/4/25. LN 22 stated there were missed entries for medication administration of Merrem for Resident 97 on 4/2/25 and 4/3/25 at 6 A.M. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN 22 stated there were missed PICC line care for Resident 97 on 4/1/25 and 4/2/25 and 4/3/25. LN 22 stated the order was to flush the PICC line every antibiotic dose. LN 22 stated she did not see any documentation from other LNs if the medications were administered per the physician's order and the PICC line care was rendered. LN 22 stated, If it was not documented, it was not given. On 4/24/25 at 10:38 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the LNs to follow the physician's orders, IV medication should have been administered and PICC line care should have been provided for Resident 97 to clear the infection as soon as possible. A review of the facility's undated policy titled, Nursing Services, Physician Orders, indicated, .It is the policy of this facility to .implement orders in addition to medication orders (treatment, procedures) . A review of the facility's undated policy titled, Documentation, Charting and Documentation, indicated, The resident's clinical record is a concise account of treatment, care .and progress of the resident's condition . Rules for Charting .5. All medications and treatments will be documented accurately .

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	555326	A. Building B. Wing	04/24/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to follow the physician's order related to pressure ulcer (a localized injury to the skin and underlying tissue caused by prolong pressure), treatment and prevention for one of four residents (Resident 43), reviewed for pressure ulcers. This failure had the potential for worsening or additional pressure ulcers to occur. Findings: Resident 43 was admitted to the facility on [DATE], with diagnoses which included cellulitis (a bacterial infection of the skin and the underlying tissues) of the lower extremities, along with sepsis (a serious condition in which the body responds improperly to an infection), per the facility's Admission Record. An observation and interview was conducted with Resident 43 on 4/21/25 at 8:25 A.M., as she sat in bed. Resident 43 had a padded green boot on her left foot and both heels were resting directly on the mattress. Resident 43 stated she got a wound on her left heel, after her legs swelled up from an infection. A review of Resident 43's medical record was conducted on 4/21/25. According to the physician's order, dated 3/18/25, foam boots on bilateral (both) feet every shift for deep tissue injury (DTI-damage to the deeper layers of the skin and underlying tissues, like muscle and fat, caused by pressure). An additional physician's order, dated 4/3/25, Cleanse left heel pressure ulcer with normal saline, pat dry, apply Santyl ointment (used to remove damaged tissue from chronic skin ulcers), followed by xerofoam (a type of petrolatum-based gauze dressing used in wound care), cover with foam dressing every day shift. A review of the facility's Treatment Administration Record (TAR), dated April 2025, indicated, a wound dressing change was not conducted on 4/5/25 (Saturday). According to the care plan titled DTI to left heel, revised 4/16/25, interventions listed included administer treatments as ordered and foam boots as tolerated. Observations were conducted of Resident 43 in bed on: 4/21/25 at 12:40 P.M., 4/22/25 at 8:53 A.M., 3:42 P.M., and on 4/23/25 at 11:50 A.M. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One green foam boot was observed each time on the left heel only. An interview was conducted with the Director of Staff Development (DSD) on 4/23/24 at 10:53 A.M. The DSD stated wound treatments over the weekend were conducted by medication nurses. The DSD stated wound treatments should be performed according to the physician's order and should not be missed, because the wound could worsen or become infected. The DSD stated foam boots should be worn to prevent additional wounds from occurring on the heels or feet and to protect any existing wounds from worsening. An interview and record review was conducted with the wound treatment nurse (Tx LN) on 4/23/25 at 11:21 A.M. The Tx LN stated if wound treatments were missed, it could complicate the healing of a wound. The Tx LN stated she completed wound treatments on the weekends and if she got busy, she asked the medication nurse to assist her with wound treatments. The Tx LN stated foam boots were important to keep pressure off the heels and if they were ordered by a physician, they should be applied. The Tx LN reviewed Resident 43's TAR for April 2025, and stated a treatment was not documented on 4/5/25. The Tx LN stated if the treatment was not documented, then it was not done, which could compromise the wound. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated if a wound treatment was missed, the wound could deteriorate and become infected. The DON stated she expected all wound treatments to be performed per the physician's order. The DON stated foam boots were important to minimize the risk of wounds to the feet and heels. The DON stated both foam boots should have been applied to Resident 43, as ordered by the physician. According to the facility's policy, titled Pressure Ulcer Management, undated, .7. Treatments will be documented accurately and in a timely manner . According to the facility's policy, titled Physician Orders, undated, .It is the policy of this facility to accurately transcribe and implement orders .in accordance with the resident's plan of care .

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	555326	A. Building B. Wing	04/24/2025

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F 0689 Level of Harm - Minimal harm or potential for 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** 39220 Based on observation, interview, and record review, the facility failed to provide supervision during toileting for a resident identified as high risk for falls. In addition a gait belt (a safety device used by caregivers to assist residents with mobility issues), was not utilized during transferring the resident from bed to a bedside commode for one of three residents (Resident 220), reviewed for accidents. These failures could potentially contributed to Resident 220 having an unwitnessed fall in the room. Findings: Resident 220 was admitted to the facility on [DATE], with diagnoses which included displaced fracture of the right tibia (lower leg bone) and right patella (knee), per the facility's Admission Record. An observation and interview was conducted with Resident 220 on 4/21/25 at 9:23 A.M. Resident 220 was sitting up in bed with a sling and partial splint on her left forearm. Resident 220 stated she fell four days ago, while using the bedside commode, resulting in a fractured left wrist. A bedside commode was observed against the wall, near the foot of the bed. On 4/22/25, Resident 220's clinical record was review. According to the physician's order, dated 4/8/25, partial weight bearing to right lower extremity every shift, knee immobilizer (splint used to stabilize) for out of bed activities. According to the facility Fall Risk Evaluation, dated 4/8/25, Resident 220's score was 12, indicating a high risk for future falls. According to the facility's care plan, titled High Risk for Falls related to weakness and impaired mobility, dated 4/8/25, interventions listed included: Bedside commode to assist with continence, Privacy curtain will be utilized per patient request during toileting, ok for staff to stay within safe distance. According to the facility's Change of Condition Evaluation, dated 4/16/25, Resident 220 was found sitting on the floor with obvious deformity noted to the left wrist. Resident 220 stated she was on the bedside commode, stood up to use the walker, and the commode shifted behind her, resulting in a fall. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was conducted with Resident 220 on 4/22/25 at 9:14 A.M., as the resident sat up in bed. Resident 220 stated the nurse told her she was going to leave, in order to give the resident privacy. Resident 220 stated when she was done using the commode, she stood up, grabbed the walker in front of her, and leaned forward to get the call light that was resting on the bed, but the commode behind her moved and she fell . Resident 220 stated she yelled for help until someone came to help her. An interview was conducted with certified nursing assistant 11 (CNA 11) on 4/22/25 at 9:46 A.M. CNA 11 stated on the day of the fall, she had assisted Resident 220 to the bedside commode and then left to provide privacy by waiting outside. CNA 11 stated she left the outside of Resident 220's room, when she responded to an emergency call light down the hall. CNA 11 stated approximately ten minutes later, after initially assisting Resident 220 to the bedside commode, she was as informed by other staff that Resident 220 had an unwitnessed fall in her room. CNA 11 stated she did not utilize a gait belt at the time of transfer, because the resident had a walker to grab onto. CNA 11 stated she did not apply the resident's knee immobilizer for the transfer to the commode. A follow up observation and interview was conducted with CNA 11 inside Resident 220's room on 4/22/25 at 3:08 P.M. CNA 11 demonstrated where she placed the bedside commode, which was at the foot of the bed, directly next to the bottom mattress. CNA 11 demonstrated where the call light was placed, by unclipping the call light from the bedsheet and pulling it down to the end of the bed, resting it on top of the mattress. The resident's immobilizer was resting in the wheelchair, which was against the wall near the head of the bed. No gait belts were observed in the room or on CNA 11. CNA 11 stated she left Resident 220 alone for privacy, after the resident asked her to. An interview was conducted with the Treatment Nurse (Tx LN) on 4/23/25 at 10:23 A.M. The Tx LN stated if a resident was identified as a high fall risk and wanted to use a bedside commode, the staff should stand behind the resident's privacy curtain or right outside the doorway. The Tx LN stated staff should never leave a resident on a bedside commode, who was identified as a high fall risk. The Tx LN stated gait belts should always be used when moving a high fall risk resident, to help support the resident and to prevent falls. An interview was conducted with Licensed Nurse 11 (LN 11) on 4/23/25 at 10:26 A.M. LN 11 stated staff should always stay in the room with a high fall risk resident when out of bed, for supervision. An interview was conducted with the Director of Staff Development (DSD) on 4/23/25 at 10:52 A.M. The DSD stated residents identified as high fall risk should never be left alone, when out of bed. The DSD stated she was aware of Resident 220's fall and the CNA should have stayed and should not have left the resident while on the commode. The DSD stated when the CNA left for an emergency call light, she should have informed another staff member to assist Resident 220. The DSD stated a gait belt should always be utilized whenever assisting a resident with limited ambulation, especially with a resident who was identified as a high fall risk. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated Resident 220's supervision should have been better. The DON stated a gait belt and the knee immobilizer should have been utilized. The DON stated they could have done better. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy, titled Fall Management System, undated, .Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents . According to the facility's policy, title Gait Belt, undated, .2. Gait belts must be used when transferring and ambulating residents .

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	555326	A. Building B. Wing	04/24/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to follow its Bowel and Bladder protocol for two of two residents (Resident 214 and 104) reviewed for Bowel and Bladder when: 1. The constipation bowel regimen was not implemented after three days of no bowel movement for Resident 214; and, 2. The urine output (UO) was not consistently documented for Resident 104, who had a urinary catheter (a tube inserted into the bladder to aid in urine flow). This failure had the potential for increased and unnecessary pain for Resident 214, along with no consistent monitoring of urine output for Resident 104. Findings: 1. Resident 214 was admitted to the facility on [DATE], with diagnoses which included orthopedic aftercare related to cervical (spine in the neck) disc disorder, per the facility's Admission Record. An observation and interview was conducted with Resident 214 on 4/22/25 at 8:41 A.M., as he laid in bed. Resident 214 was rubbing his abdomen, stating he felt discomfort and bloating. Resident 214 stated he had not had a bowel movement in several days and they had given him a suppository last night, but nothing had happened yet. A follow up observation and interview was conducted with Resident 214 in his room on 4/23/25 at 7:59 A.M. Resident 214 stated they had given him an additional suppository last night, but still nothing had happened. Resident 214 stated he felt bloated and uncomfortable, and he did not know how much longer he could go on like this. Resident 214's clinical record was reviewed on 4/23/25. According to the facility's Task Documentation, Resident 214 had not had a bowel movement since his admission on 4/17/25 (six days). According to the physician's order, dated 4/17/25: - Docusate Sodium oral liquid (Dulcolax-a stool softener) two times a day for bowel movement. - Lactulose oral solution (use to treat constipation) twice a day for constipation. - Lactulose oral solution every 24 hours as needed for bowel care if no bowel movement in three days. - Mineral oil enema if not relieved by Dulcolax or Lactulose. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) was reviewed for April 4/17/25 through 4/22/25. - Dulcolax and Lactulose oral liquid had been administered twice a day as ordered. - Lactulose every 24 hours if no bowel movement in three days was never administered. - Mineral enema had not been administered as ordered, .if not relieved by Dulcolax or lactulose. The MAR for April 2025, indicated one Dulcolax suppository was and administered on 4/21/25 at 8:08 P.M. An interview and record review was conducted with Licensed Nurse 11 (LN 11) on 4/23/25 at 10:26 A.M. LN 11 stated the facility's bowel protocol indicated if no bowel movement (BM) after three days, staff was to follow the physician's order for medication administration. LN 11 reviewed Resident 114's MAR and stated he was a high risk for constipation because of his pain medication and lack of mobility. LN 11 stated she could find no documented evidence a mineral enema or the Lactulose was administered after the third day. LN 11 stated the nurses should have recognized the lack of BM sooner and the orders for BM protocol should have been implemented. LN 11 stated the delay in treatment could have caused increased pain and discomfort. LN 11 stated the BM protocol should have been followed and it was not. An interview was conducted with the Director of Staff Development (DSD) on 4/23/25 at 10:52 A.M. The DSD stated Certified Nursing Assistants (CNAs) were expected to inform Licensed Nurses if residents had not had a BM within three days. The DSD stated they have a BM protocol and the physician's write specific orders for staff to follow. The DSD stated BMs were important to prevent discomfort and pain to the residents. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated she expected the LNs to check the bowel schedule of residents and for the CNAs to inform the nurses if no BM within three days. The DON stated all residents had orders to prevent constipation which start with Dulcolax, Lactulose, and then an enema. The DON stated with delayed bowel movements, residents were at risk of increased pain. The DON stated Resident 214's bowel regimen was not followed and it should have been captured sooner. According to the facility's policy, titled Bowel Care Management, undated, It is the policy of this facility to follow the physician orders and implement bowel care interventions. 1. Licensed nurses will monitor bowel movements every shift 3. Licensed nurses will administer bowel care as ordered to residents who trigger .as not having a bowel movement in 3 days . 40610 2. Resident 104 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should) and urinary retention, per the facility's Admission Record. A record review was conducted of Resident 104. Resident 104's History and Physical dated 3/7/25, indicated Resident 104 had the capacity to make own decisions. (continued on next page)

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	555326	A. Building B. Wing	04/24/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review was conducted of Resident 104. Resident 104's minimum data set (MDS - a federally mandated resident assessment tool), dated 3/13/25, indicated Resident 104's brief interview for mental status (BIMS, ability to recall) score was 15/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact). Resident 104's MDS section for bladder and bowel indicated Resident 104 had a urinary catheter. On 4/21/25 at 12:53 P.M., an observation and an interview of Resident 104 was conducted in his room. Resident 104 had a urinary catheter attached to his wheelchair. Resident 104 stated he had the urinary catheter because he underwent back surgery. On 4/23/25 at 8:47 A.M., an observation and an interview of Resident 104 was conducted in his room. Resident 104 was sitting up in bed and a urinary catheter was attached to the bed rails. Resident 104 stated he retained fluids and experienced a distended bladder because he could not urinate properly. Resident 104 stated the staff emptied the urinary catheter, collected the urine into a urinal and discarded the urine to the toilet bowl. On 4/23/25, a review of Resident 104's clinical record was conducted. Resident 104's physician's order and care plan (detailed plan with information about a patient's treatment, goal, and interventions) dated 3/6/25 indicated to measure, monitor and document Resident 104's urine output (UO) for 30 days. A review of Resident 104's record of urine output for March and April 2025 was conducted. The record had missed entries of UO for Resident 104 on the following dates and shifts: 3/6, 3/14, 3/18, 3/19 - nocturnal shifts (from 11 P.M to 7 A.M.) 3/8, 3/18, 3/19, 3/20, 3/31, 4/2 through 4/5 - morning shifts (7 A.M to 3 P.M.) 3/7, 3/8, 3/11, 3/13, 3/20, 4/1, 4/2 through 4/4 - afternoon shifts (3 P.M to 11 P.M.) 3/16, 3/17, 3/22 through 3/30 - no entries for all shifts. On 4/23/25 at 11:28 A.M., a joint review of Resident 104's clinical record and an interview was conducted with LN 21. LN 21 stated Resident 104 retained urine and had a fluid restriction of two liters per day. LN 21 stated it was important to monitor Resident 104's UO to ensure Resident 104 was not retaining fluids to prevent him from getting a distended bladder. LN 21 stated Resident 104's UO should have been monitored and documented, but it had not been. LN 21 stated the CNAs emptied and tracked Resident 104's UO and documented in a log. LN 21 stated the staff did not consistently monitor and document Resident 104's UO per physician's order and per facility's policy. On 4/24/25 at 10:38 A.M., an interview was conducted with the DON. The DON stated the expectation was for the licensed staff to monitor Resident 104's UO to ensure Resident 104 did not have bladder distention, and for Resident 104's comfort. A review of the facility's undated policy titled, Intake and Output Documentation, indicated, It is the policy of this facility that fluid intake and output shall be recorded for each resident with an indwelling .catheter or as prescribed by the physician .Procedures .2. The .output information is to be recorded at the end of each shift by a Licensed Nurse .

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	555326	A. Building B. Wing	04/24/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to ensure dialysis (the process of cleaning the blood through a machine) access site was properly cared for one of one resident reviewed for dialysis (Resident 87). This deficient practice had the potential for Resident 87's dialysis access to clot. Findings: Resident 87 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (kidney failure), per the Admission Record. On 4/21/25 at 10:34 A.M., an observation and an interview were conducted of Resident 87 in her room. Resident 87 was up in her wheelchair. Resident 87 stated she went for dialysis Tuesdays, Thursdays and Saturdays and showed her right arm dialysis access site. On 4/22/25 at 2:37 P.M., an observation of Resident 87 was conducted. Resident 87 arrived at the facility from the dialysis via wheelchair and noted a dressing to right upper dialysis access site. On 4/23/25 at 8:09 A.M., an observation and an interview were conducted of Resident 87 in her room. Resident 87 sat in a wheelchair with a soiled dressings noted on her right upper dialysis access site. Resident 87 stated the Licensed Nurses (LNs) did not remove the dressings on her (Resident 87) right upper arm. On 4/23/25, a review of Resident 87's communication record (communication record between the dialysis center and the facility) was conducted. The dialysis communication record indicated the dressing was to be removed after four to six hours after dialysis. On 4/23/25 at 11:13 A.M., a joint review of Resident 87's clinical record and an interview was conducted with Licensed Nurse (LN) 21. LN 21 stated Resident 87 went for dialysis three times a week. LN 21 stated when residents came back from dialysis treatment, the LNs were to get the dialysis communication record to check if there was new order from dialysis center. LN 21 stated he did not change or deal with Resident 87's dialysis dressings. LN 21 stated he was not aware Resident 87's dialysis access dressings were to be removed at a specific time after dialysis. LN 21 stated he did not read the communication record from the dialysis center. On 4/23/25 at 3:28 P.M., an interview was conducted with LN 23. LN 23 stated she was familiar with Resident 87. LN 23 stated when Resident 87 came back from dialysis treatment, the LNs were supposed to read the communication record to be aware of any updates or changes for Resident 87. LN 23 stated she did not do anything with the dressings of Resident 87's dialysis access site. LN 23 stated she was not aware the dressing was to be removed four to six hours after the resident received dialysis treatment. LN 23 stated the dialysis access site of Resident 87 should be free from any pressure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 10:38 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the LNs should have removed the dressings of Resident 87, four to six hours after the resident's dialysis treatment to prevent clotting of the dialysis access. A review of the facility's undated policy, titled Renal Dialysis, Care of Resident, indicated, It is the policy of this facility to provide standards in the care of the residents on renal dialysis and the care of the vascular access site for hemodialysis .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to maintain proper food sanitation procedures when expired food was identified in the kitchen refrigerators, and in the nursing unit refrigerator. These failures had the potential to cause foodborne illness to the residents who received food from the kitchen and/or nursing unit refrigerator. Findings: A concurrent kitchen tour and interview with the Dietary Services Supervisor (DSS) was conducted on [DATE] at 8:23 A.M. In the walk-in refrigerator, a bag containing approximately eight ounces of shredded parmesan cheese was found to have a Use By Date of [DATE]. A reach-in refrigerator contained six small plastic containers of peaches, with a Use By Date of [DATE]. The DSS stated both foods should have been disposed of on the Use By Date. The DSS stated expired food had the potential to cause foodborne illness to the residents. A concurrent observation of nursing unit refrigerators and an interview with a Nurse Manager (NM 1) was conducted on [DATE] at 10:45 A.M. Three containers of expired yogurt was identified. NM 1 stated the yogurt should have been thrown away, and it was her job to check the refrigerator for dates. An interview was conducted with the Registered Dietitian (RD) on [DATE] at 11 A.M. The RD stated residents were allowed to bring food from home, and it was the staff members' responsibility to label and date the foods. The RD stated the nursing staff, as well as kitchen staff, was responsible for ensuring foods were labeled and dated, and also to dispose of items by their expiration date. The RD stated it was important to monitor the refrigerated foods for expiration date to prevent foodborne illness to the residents. Per a facility policy, dated 2023 and titled Labeling and Dating of Foods, Policy: All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety .The Use By date will be the absolute date in which the food must be consumed or discarded by the facility .Once daily, the PM [NAME] and/or PM Diet Aide will be responsible to inspect the refrigerators and discard perishable foods .in order to ensure food safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to accurately document the correct extremity involved in their weekly wound evaluation summary for one of four residents (Resident 43), reviewed for wound care. This failure had the potential for confusing and misleading information in Resident 43's clinical record. Findings: Resident 43 was admitted to the facility on [DATE], with diagnoses which included cellulitis (a bacterial infection of the skin and the underlying tissues), in the lower extremities along with sepsis (a serious condition in which the body responds improperly to an infection), per the facility's Admission Record. An observation and interview was conducted with Resident 43 on 4/21/25 at 8:25 A.M., as she sat in bed. Resident 43 had a padded green boot on her left foot and both heels were resting directly on the mattress. Resident 43 stated she got a wound on her left heel, after her legs swelled up from an infection. Resident 43's clinical record was reviewed on 4/22/25. According to the physician's order, dated 4/3/25, cleanse left heel wound with normal saline, pat dry, apply Santyl ointment (used to remove damaged tissue from chronic skin ulcers), followed by xerofoam (a type of petrolatum-based gauze dressing used in wound care), cover with foam dressing every day shift. According to the facility's weekly wound evaluations conducted on 3/17/25 and 3/31/25, the wound was identified and measured as being on the right heel, instead of the left heel. An interview and record review was conducted with the wound Treatment Nurse (Tx LN) on 4/23/25 at 11:21 A.M. The Tx LN reviewed Resident 43's weekly wound evaluations for 3/17/25 and 3/31/25, and stated they were incorrect because the wound was on the left heel, not the right. The Tx LN stated the inaccurate documentation could confuse the reader and provide inaccurate information. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated weekly wound evaluations should be accurate and concise. The DON stated documenting the wrong extremity could confuse the reader and she expected the location and description to be correct. According to the facility's policy, titled Documentation, undated, .6. All wounds and treatments will be accurately documented in the resident's record .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 40610 Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility) deficient trends found by surveyors during the recertification survey concerning call light response and the lack of homelike environment for the residents. This failure had the potential for the facility to overlook trends in resident care that might have affected residents' health and quality of life. Cross Reference: F558, F584 Findings: On 4/24/25 at 2:18 P.M., a concurrent interview with the Administrators (ADM 1 and ADM 2), the Director of Nursing (DON) and a review of QAPI program was conducted. The ADMs stated that the main areas that the QAPI team were monitoring were falls, pressure ulcer reduction, weights and urinary tract infection prevention. During the recertification survey, deficient trends in call light response and the lack of homelike environment were identified. The DON stated that call light response was an ongoing project, but when asked about the root cause of the call light issues, the facility was unable to identify one. The DON stated identifying the root cause of the call light issues was challenging. The DON stated it was important to work towards a reduction in complaints related to call light response. Regarding the lack of homelike environment, ADM 1 stated there had been a budget approved for residents' room improvements, but this had not been included in the QAA Committee and/or included in the QAPI plan. Review of the facility policy titled Quality Assurance and Performance Improvement dated January 2025 indicated .The purpose of the QAPI Plan and processes is to continually assess the facility's performance in all service areas, so that concerns and processes achieve the delivery of person-centered care, and which maximizes the individual's highest physical, mental, and social well-being .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review, the facility did not follow infection control practices when: 1) Staff did not don (put on) and doff (remove) Personal Protective Equipment (PPE- gown, gloves, mask) or perform hand hygiene when providing care to a resident on Enhanced Barrier Precautions (EBP, use of PPE when providing high contact resident care to reduce the spread of bacteria), and, 2) Two ice scoops were not stored in a sanitary manner. As a result, there was the potential for cross contamination, affecting the health of residents. Findings: 1a. According to the Admission Record, Resident 316 was admitted on [DATE] with diagnoses which included fractures (broken bones) of the vertebra (spinal column), and muscle weakness. During an observation on 4/21/25 at 7:54 A.M., a sign was observed outside Resident 316's room which indicated EBP. A blue sticker was observed next to Resident 316's name, outside the room. A container filled with PPE was observed outside the room. On 4/21/25 at 7:54 A.M., Certified Nursing Assistants (CNA) 31 and 32 were observed entering Resident 316's room without performing hand hygiene, and without donning PPE. CNA 31 and CNA 32 were observed donning gloves inside the room, then pulled Resident 316's curtain. On 4/21/25 at 8 A.M., during a concurrent observation and interview in the hallway outside Resident 316's room, CNA 31 opened Resident 316's curtain, removed her gloves, and walked out of Resident 316's room without performing hand hygiene. CNA 31 stated the blue sticker next to Resident 316's name indicated Resident 316 was on EBP precautions, and PPE needed to be donned prior to providing high contact activities. CNA 31 stated she forgot to perform hand hygiene before and after entering the room, and don PPE prior to entering the room. CNA 31 stated, .we are supposed to gown up .whether its for [brief] changes, transferring them, toileting, repositioning. We lifted her up in bed. We should have gowned up . On 4/21/25 at 8:05 A.M., a concurrent interview and record review was conducted with CNA 32. CNA 32 stated the EBP sign posted outside Resident 316's room indicated PPE was required for high contact care, such as mobility assistance. CNA 32 stated she should have done hand hygiene before putting gloves on, and after removal. CNA 32 further stated she should have followed the guidance posted on the EBP sign. CNA 32 stated, I honestly just forgot to [don PPE] .I just had tunnel vision and went inside [Resident 316's room]. It always says up there [on the EBP sign posted] what you have to wear . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/25 at 12:32 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, The staff need to adhere to practicing proper hand hygiene .they need to adhere to Enhanced Barrier Precautions. If they need to gown up, they are expected to gown up prior to entering the room .for prevention of contamination and to practice infection control for the safety of the residents and staff . A review of the Policy and Procedure titled, Handwashing/Hand Hygiene, dated 2021, indicated, .The facility considers hand hygiene as the primary means to prevent the spread of health care associated infections .All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infection to .residents use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations: b. Before and after direct contact with residents; d. Before performing any non-surgical invasive procedures .r. After removing and disposing of personal protective equipment . 1b. On 4/21/25 at 9 A.M., the Certified Phlebotomy Technician (CPT, person who draws blood) was observed drawing blood in a resident room identified as EBP precautions required. The CPT was observed wearing gloves and a surgical mask, but not a gown. A plastic container with laboratory supplies was placed directly on the resident's bed. On 4/21/25 at 9:07 A.M., the CPT was observed walking out of the resident's room with gloves on, holding the plastic container. The CPT placed the plastic container on top of the cart without disinfecting. On 4/21/25 at 9:29 A.M., an interview was conducted with the CPT. The CPT stated the resident was on EBP. The CPT stated, .I'm only drawing her blood, so I only have to wear a glove and mask .I don't know exactly what she has. The CPT stated drawing blood was not one of the high contact activities listed on the EBP signage posted outside the resident's door. On 4/23/25 at 3:35 P.M., an interview was conducted with the Infection Preventionist (IP). The IP stated it was important for staff to perform hand hygiene before and after using gloves, and to don and doff PPE when providing high contact activities to a resident in an EBP room. The IP stated the high contact activities listed on the EBP signage was not all-inclusive. The IP stated drawing blood was considered a high contact activity, and it was her expectation that staff put on a gown and gloves, .to avoid coming into contact with bodily fluids .it is important to don and doff PPE in an EBP room and to do hand hygiene to avoid cross contamination . The IP stated items that were placed on the resident's bed should have been sanitized prior to placing on the phlebotomy cart because it could have contaminated other items on the cart. A review of the undated facility Policy and Procedure titled, IPCD Standard and Transmission-Based Precautions indicated, EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities . 39220 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An observation was conducted of Station 2's ice/water station on 4/21/25 at 3:54 P.M. The ice/water station contained three shelves with an ice chest and water cooler on the second shelf. The metal ice scoop was on the top shelf, resting inside a square metal container. The metal container was not covered, and it had no drainage for accumulated water. The metal scoop container was observed with an estimated one to three tablespoons of water on the bottom of the container with the metal scoop in direct contact with the water. An observation was conducted of Station 1's ice/water station on 4/22/25 at 7:50 A.M. The ice/water station contained three shelves with an ice chest and water cooler on the second shelf. The metal ice scoop was on the bottom shelf resting in a square metal container. The metal container was not covered, and it had no drainage for accumulated water. The metal scoop container had an estimated one to three tablespoons of water at the bottom of the container with the metal scoop in direct contact with the water. An observation and interview was conducted with the Tx LN of Station 1's ice/water station on 4/23/25 at 10:21 A.M. The Tx LN viewed the metal scoop container on the bottom shelf and stated there was about a half inch of water in the metal container. The Tx LN stated the scoop should be considered contaminated because it was not covered, and it was resting in stagnate water. The Tx LN stated if the ice scoop was used to get ice from the ice chest, it could contaminate all the ice, potentially resulting in resident's getting sick. An observation and interview was conducted with the Registered Dietitian (RD) on 4/23/25 at 10:23 A.M., of Station 1's ice/water station. The RD viewed the metal ice scoop resting inside the metal container with approximate a half inch of water. The RD stated the ice scoops should be covered, and the container should have drainage, to prevent cross contamination. An observation was conducted on of Station 2's ice/water station on 4/23/25 at 11 A.M. The RD replaced the ice scoop holder with a clear plastic container with a lid, but no drainage device was added. A follow up observation was conducted of Station 2's ice/water station on 4/24/25 at 8:45 A.M. On the top shelf was an uncovered square metal container, which contained a metal scoop. Scant water was inside the bottom of the metal container. A follow up observation and interview was conducted with the RD of Station 2's ice/water station on 4/24/25 at 9:10 A.M. The RD stated she will have the kitchen staff correct it immediately, and get a closed container for the ice scoop. An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 9:11 A.M. The DON stated she expected ice scoops to be covered when not in use and to have drainage, in order to prevent cross contamination. According to the facility's policy titled Infection control, undated, .1. Standard Precautions are infection prevention practices that apply to the care of all residents .e. Environmental cleaning and disinfection .