STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555362	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Las Campanas	18655 W. Bernardo Drive San Diego, CA 92127

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications and nutritional supplements were properly stored for 3 out of 4 medication storage rooms reviewed for medication storage and for one of four residents when:1. Resident 78 had medications unsecured at bedside,2. Station one medication room had an expired medication, and a bottle of nutritional supplement,3. Expired medications and a box of nutritional supplements were stored in the main central supply room.These failures had the potential for unsafe and ineffective use of medications and supplements with decreased therapeutic effectiveness when used past the expiration date. In addition, this failure had the potential for Resident 78's medications to be accessible to unauthorized staff and residents.Findings:1. Resident 78 was admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure) and diabetes (too much sugar circulating in the blood) according to the facility's admission Record.During observation and interview on 8/6/25 at 3:10 P.M., Resident 78 stated she kept the eye drops at her bedside. Resident 78 took a paper cup from the overbed table and showed three eye drops inside the cup: gen teal, optase {for dry eyes) and gentamicin (an antibiotic). Resident 78 stated she applied one of the eyedrop herself but called for a nurse to administer the other eye drop because it was thicker and difficult to self-administer.An interview with Licensed Nurse (LN) 1 was conducted on 8/6/25 at 3:27 P.M. LN 1 stated it was important not to keep medications at bedside because the resident may double dose.During an interview on 8/8/25 at 8:30 A.M. with the Infection Preventionist (IP), the IP stated if a resident requested to self-administer medications a lock box will be provided for the resident and the medication nurse will check if the resident was taking the medication.An interview was conducted on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON). The ADON stated Resident 78 should have a lock box for safety.A review of the facility's undated policy and procedure (P&P) titled, Self-Administration of Medications was conducted. The P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team [IDT-team members with various areas of expertise who work together toward the goals of their resident] has determined that it is clinically appropriate and safe for the resident to do so.If it is deemed safe and appropriate for a resident to self- administer medications, this is documented in the medical record.Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.2. On 8/7/25 at 10 A.M. a concurrent observation of station one medication room and interview was conducted with LN 3. LN 3 checked the medications inside a cabinet for expiration dates. LN 3 found a bottle of ibuprofen (pain medication) 200 mg (milligrams) with an expiration date of 7/20/25. On an open shelf in the medication room, a bottle of juven (nutritional supplement) was observed. LN 3 stated the juven bottle had an expiration date of 8/1/25. 3. On 8/7/25 at 10:14 A.M. a concurrent observation of the main central supply room and interview was conducted with LN 3. Upon entrance to the supply room, a shelf on the left was observed with two bottles of povidone iodine (used to disinfect the skin) with expiration dates of 8/2025. On another shelf on the other side of the room, a box which contained 24 (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottles of boost (a nutritional supplement) had an expiration date of 5/19/25 written on the box. LN 3 showed a metal file drawer with bisacodyl suppository (medication for constipation) which indicated an expiration date of 8/2025. During an interview with LN 3 on 8/7/25 at 10:32 A.M., LN 3 stated it was important not to have expired medications and nutritional supplements due to possible adverse effects and the desired indication of the medications or nutritional supplements would not be achieved if expired. During an interview on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON), the ADON stated stored medications should not be expired for others to have access to. The ADON further stated expired medications, or nutritional supplements will lose potency, and it was important for resident safety. A review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 1/2025 was conducted. The (P&P) indicated, Medications and biologicals [medicines derived from human blood and plasma] are stored properly.to keep their integrity and to support safe, effective drug administration.Outdated, contaminated, discontinued or deteriorated medications.are immediately removed from stock, disposed of according to procedures of medication disposal.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food served was in a palatable, flavorful manner, and at the preferred temperature for six residents who complained about the food's taste and temperature. The facility had a census of 50.This failure had the potential for residents to decrease meal intake and lead to weight loss.Findings:On 8/5/25, during the facility's initial tour, there were six residents who had complained that the food was not palatable and the warm food was served cold.On 8/7/25 at 11:30 A.M., the trayline was observed serving the following items: Spanish fish soup, spaghetti [NAME], garlic bread, chicken pea stuff peppers, rainbow chard, roasted beets, charred purple potatoes, sticky rice, and spinach.A review of the Hot and Cold Food Temperature Logs, dated 8/7/25, indicated that the soup was 171 degrees Fahrenheit, the main entree was 161 degrees Fahrenheit, and the milk was 36.2 degrees Fahrenheit.On 8/7/25 at 12:25 P.M., a test tray sample was conducted with the Dietary Manager (DM). The DM tested the temperature of the foods; the soup was 157 degrees, indicating a 14-degree drop in temperature. The spaghetti [NAME] was 139.8, which meant the temperature of the food dropped to 21.2 degrees cooler. The temperature of the milk was 40 degrees Fahrenheit. The flavor of the spaghetti [NAME] was flat, noticeably lacking in salt, and the complexity of the rich taste of the seasoning was missing. The DM tried the food and said the taste could be improved.On 8/7/25 at 12:45 P.M., an interview was conducted with Resident 85. Resident 85 stated that the green substance on his tray was unrecognizable, possibly kale or spinach, but he was unsure. Resident 85 further stated he did not eat it.A review of Resident 85's medical records was conducted. Per the Minimum Data Set (MDS- comprehensive evaluation of a resident's health and functional status), under Section C- Cognitive Patterns, Resident 85's Brief Interview for Mental Status (BIMS-tests mental score) score was 13, indicating no cognitive impairment. Per the Order Listing Report, dated 7/31/25, Resident 85 had a diet order of regular diet and regular texture.On 8/7/25 at 12:52 P.M., an interview was conducted with Resident 86. Resident 86 stated that the spaghetti did not have flavor, and she sent it back to the kitchen.A review of Resident 86's medical records was conducted. Per the Minimum Data Set (MDS), under Section C- Cognitive Patterns, Resident 86's Brief Interview for Mental Status (BIMS) score was 15, indicating no cognitive impairment. Per the Order Listing Report, dated 8/1/25, Resident 86 had a diet order of regular diet and regular texture.On 8/7/25 at 1 P.M., an interview was conducted with Resident 89. Resident 89 stated that he tried the spinach and stated It's bad and the texture was not right.A review of Resident 89's medical records was conducted. Per the Minimum Data Set (MDS), under Section C- Cognitive Patterns, Resident 89's Brief Interview for Mental Status (BIMS) score was 12, indicating no cognitive impairment. Per the Order Listing Report, dated 7/30/25, Resident 89 had a diet order of no added salt, regular texture diet.On 8/8/25 at 10:45 A.M., an interview was conducted with DM. The DM stated the importance of serving palatable and resident-preferred temperature foods was to ensure residents enjoy the food and do not lose weight. Facility did not provide a policy regarding food palatability and temperature.

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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. Based on interview and record review, the facility failed to ensure food items in the reach-in refrigerator in the kitchen had an open date, and expired food was not removed for two of two reach-in refrigerators. This failure placed residents at risk of acquiring foodborne illness. Findings:On 8/5/25 at 8 A.M., an initial tour of the kitchen area was conducted with the Dietary Aide (DA). Inside the reach-in refrigerator was a large tub of opened cottage cheese, with no indication of when it had been opened. The DA stated the food item should have had an open date written on the container. Upon further observation of the reach-in refrigerator below the cottage cheese was a pack of sliced cheese that was torn open and had a smeared black marker written on the front of the package. The date was unreadable. The DA stated that the open cheese should be dated and securely wrapped with plastic wrap or a sealable bag. The DA further stated she could not make sense of the date that was written. In addition, there was a large container of sliced peaches inside the clear container with a label Use By: 8/1/25. The DA stated the peaches should have been removed to ensure it was not served to the residents by mistake. On 8/7/25 at 8:48 A.M, an interview was conducted with the Dietary Manager (DM). The DM stated food items in the kitchen should be labeled and dated and expired food items should have been removed. The DM further stated it was important to label, date, and remove expired food items to ensure resident safety. Per the facility's protocol, titled Trayline Labeling & Dating Guidelines, dated 4/23/25, Cottage cheese and sliced cheese were good for 6 days. ALL ITEMS MUST BE DATED & SECURELY COVERED. Facility did not provide a policy regarding food storage.

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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** Based on observation, interview, and record review the facility failed to implement infection control standards of practice when:1. An used syringe was found on top of a resident's dresser (Resident 2), and2. A blood pressure cuff was used for multiple residents without sanitizing in between use for four of four residents observed during medication pass. This failure had the potential to spread infection amongst the residents.Findings: 1. On 8/5/25 at 10:20 A.M., during the initial tour, Resident 2 was observed lying in bed, with an indwelling catheter (flexible tube that drains urine) hooked on the side of the metal frame bed. On top of Resident 2's dresser was an unwrapped, uncovered, clear, plastic syringe. Resident 2 stated she did not know if she had an indwelling catheter or stoma (surgical opening on the body). On 8/5/25 at 10:30 A.M., a joint observation and interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was not aware of the reason why there was a used syringe on Resident 2's dresser. On 8/5/25 at 10:38 A.M., an interview was conducted with Licensed Nurse (LN) 4. LN 4 stated Resident 2 had an indwelling catheter changed and urine collection last week. LN 4 further stated the used syringes should have been disposed of. On 8/7/25 at 3:30 P.M., an interview was conducted with the Infection Preventionist (IP). The IP stated the plastic syringe was one-time use, and should have been disposed of after use to prevent cross-contamination. Per the facility's policy and procedure, dated 8/2022, titled Indwelling (Foley) Catheter Insertion, Female Resident, .13. Clean the area and reposition the resident: a. Discard all disposable items into designated containers . 2. Resident 1 was admitted to the facility on [DATE] with diagnoses including sepsis (the body's extreme and life-threatening response to an infection) and hypertension (high blood pressure) according to the facility's admission Record. Resident 60 was admitted to the facility on [DATE] with diagnoses including hypertension according to the facility's admission Record. Resident 25 was re-admitted to the facility on [DATE] with diagnoses including hypertensive heart (heart condition caused by long-term high blood pressure) and chronic kidney disease according to the facility's admission Record. Resident 48 was re-admitted to the facility on [DATE] with diagnoses including hypertension according to the facility's admission Record. A medication administration observation was conducted on 8/7/25 at 8:12 A.M. with Licensed Nurse (LN) 2. LN 2 took a portable, wrist blood pressure (BP) apparatus from a pouch on top of the medication cart and proceeded to take Resident 1's blood pressure. LN 2 did not sanitize the BP cuff prior to and after use. LN 2 returned the BP apparatus to the pouch on top of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 8:33 A.M. LN 2 took a portable, wrist blood pressure (BP) apparatus from a pouch on top of the medication cart, proceeded to Resident 60's room and took Resident 60's blood pressure. LN 2 did not sanitize the BP cuff prior to and after use. On 8/7/25 at 8:44 A.M. LN 2 took a portable, wrist blood pressure (BP) apparatus from a pouch on top of the medication cart and entered Resident 25's room. Outside of Resident 25's room a sign was posted which indicated Enhanced Barrier Precaution (EBP-an approach when healthcare workers wore gowns and gloves during high contact with residents to reduce transmission of organisms) for bed B (Resident 25's roommate). LN 2 went to Resident 25's roommate and took his blood pressure. LN 2 then went to Resident 25 and took his blood pressure without sanitizing the BP cuff in between use. LN 2 returned the BP apparatus to the pouch on top of the medication cart without sanitizing the BP cuff after use. On 8/7/25 at 9:07 A.M. LN 2 took a portable, wrist blood pressure (BP) apparatus from a pouch on top of the medication cart. LN 2 entered Resident 48's room and took Resident 48's blood pressure without sanitizing the BP cuff prior to and after use. An interview was conducted on 8/7/25 at 9:26 A.M. with LN 2. LN 2 stated she used her own BP apparatus and forgot to sanitize the BP cuff between residents. LN 2 stated it was important to sanitize to prevent the spread of infection. During an interview on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON), the ADON stated staff should sanitize BP cuffs prior to using and in between resident use for infection control. A review of the facility's undated policy and procedure (P&P) titled, Infection Control 09-Disposal and Disinfection of Care Equipment was conducted. The P&P indicated, All medical equipment used by care staff is either disposable or requires proper disinfection. Non-critical reusable medical equipment includes items that only touch intact skin, such as blood pressure cuffs, canes/wheelchairs, gait belts, etc.These items are suitable for disinfection using methods recommended by manufacturer's instructions. The policy did not provide guidance regarding frequency of disinfecting medical equipment.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess a resident's ability to self-administer medications for one of one resident reviewed for self-administration of medications. (Resident 78).This failure had the potential for Resident 78 to over medicate and affect Resident 78's health and safety.Findings:Resident 78 was admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure) and diabetes (too much sugar circulating in the blood) according to the facility's admission Record.During the initial tour on 8/5/25 at 9:08 A.M., Resident 78 was sitting at the edge of the bed with the right eye closed. Resident 78 stated the nurse applied eye drops on the right eye and she (Resident 78) applied eye drops on the left eye every hour.A review of Resident 78's physician's orders in the electronic medical record (EMR) was conducted. The physician's orders indicated, Autologous [person's own cells or tissues] serum eye drops 1 drop both eye four times a day for chronic dry eye syndrome in refrigerator patient to provide own med.GenTeal Tears [artificial tears] Severe Day/Night Ophthalmic [for the eyes] Gel Instill 1 drop in right eye every day and evening shift for dry eye syndrome every 1 hour supervised self-administration to stop at 2100[9 P.M.] , restart at 0800 [8 A.M.] AND Instill 1 drop in right eye every day and evening shift for Dry eye to stop at 2100, restart at 0800.During observation and interview on 8/6/25 at 3:10 P.M., Resident 78 stated she kept the eye drops at her bedside. Resident 78 took a paper cup from the overbed table and showed three eye drops inside the cup: gen teal, optase {for dry eyes) and gentamicin (an antibiotic). Resident 78 stated she applied one of the eyedrop herself but called for a nurse to administer the other eye drop because it was thicker and difficult to self-administer.An interview with Licensed Nurse (LN) 1 was conducted on 8/6/25 at 3:27 P.M. LN 1 reviewed Resident 78's physician's orders in the EMR. LN 1 stated Resident 78 had physician's orders for GenTeal to be administered every hour to Resident 78's right eye, erythromycin to be administered at bedtime and Optase to be administered to Resident 78's left eye every hour. LN 1 stated Resident 78 was not supposed to keep medications at bedside unless there was a physician's order, labeled with the resident's name, directions and stored properly. LN 1 stated it was important not to keep medications at bedside because the resident may double dose. LN 1 stated she was unsure of how to properly store Resident 78's medications in the room. LN 1 stated there was no assessment for Resident 78 to self-administer medications.During an interview on 8/8/25 at 8:30 A.M. with the Infection Preventionist (IP), the IP stated if a resident requested to self-administer medications an assessment of the resident will be completed. The IP further stated a physician's order will be obtained, a lock box will be provided for the resident and the medication nurse will check if the resident was taking the medication.An interview was conducted on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON). The ADON stated Resident 78 should have an assessment for self-administration of medications, a physician's order, care plan and a lock box. The ADON stated it was important to complete an assessment for Resident 78's safety.A review of the facility's undated policy and procedure (P&P) titled, Self-Administration of Medications was conducted. The P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team [IDT-team members with various areas of expertise who work together toward the goals of their resident] has determined that it is clinically appropriate and safe for the resident to do so.If it is deemed safe and appropriate for a resident to self- administer medications, this is documented in the medical record.Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide a written and follow-up initiation of the advance directives for one of 15 sampled residents (Resident 9).This failure had the potential to prevent Resident 9's wishes from being honored.Findings:Resident 9 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (lung disease), per the admission Record. Per the same document, Resident 9 was responsible for herself and had two durable powers of attorney (DPOA - a legal document that appoints someone to manage affairs if a resident becomes unable to make decisions) for healthcare and financial.A review of Resident 9's medical record was conducted. Per the History and Physical, dated 6/30/25, Resident 9 cannot understand or decide because Resident 9 had dementia (memory loss).Per the Physician Orders for Life-Sustaining Treatment (POLST), dated 6/22/24, under Section D, there was no information about the advance directive (a written statement of a resident's wishes).A further review of Resident 9's medical record was conducted. There was no documented evidence of the advance directive in Resident 9's medical records.Upon further review of Resident 9's medical record, there was no evidence that the facility offered or had follow-up about Resident 9's advance directives.On 8/7/25 at 12:11 P.M., a joint interview and record review was conducted with the Social Service Coordinator (SSC). The SSC stated that she was responsible for gathering advance directives during admission or care conferences. If a resident did not have an advance directive, she would offer one and document it in the progress notes.The SSC further stated Resident 9 did not have an advance directive in the medical record, and should have. The SSC said the importance of having an advance directive was to ensure a resident's wishes are honored when they can no longer make decisions. Per the facility's policy and procedure, dated 9/22, titled Advance Directives, .staff will document in the medical record the offer to assist. If the Resident Has an Advance Directive .copies of the documents will be obtained and maintained in the same section of the residents medical record .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's authorized responsible party had signed the informed consent for the use of the psychotropic medication (medications that affect brain activities associated with mental processes and behaviors) prior to administering the medications for one of five sampled residents reviewed for unnecessary medications (Resident 7).This failure increases the risk of inappropriate use of psychotropic medications.Findings:Resident 7 was admitted to the facility on [DATE] with diagnoses that included Dementia (loss of memory) with agitation, per the admission Record. Per the same document, Resident 7 had a Responsible Party (RP - an individual legally authorized to make decisions on behalf of a resident).A review of Resident 7's medical records was conducted. Per the Minimum Data Set (MDS- comprehensive evaluation of a resident's health and functional status), under Section C- Cognitive Patterns, Resident 7's Brief Interview for Mental Status (BIMS) score was 5, indicating severe cognitive (mental processes) impairment.Per the Physician's order, dated 12/4/24, Resident 7 started Quetiapine Fumarate (a psychotic medication) 100 milligrams (mg) every bedtime, and on 12/16/24, Resident 7 started Brexpiprazole (a psychotropic medication) 1 mg daily. A review of Resident 7's electronic medical record revealed no documented evidence of signed informed consent for either medications. A subsequent review of the paper chart indicated that the informed consent for Quetiapine Fumarate did not have the RP's signature, and no informed consent was present for Brexpiprazole.On 8/7/25 at 11:15 A.M., a joint interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 7 should have an informed consent signed by the RP before administering the psychotropic medication. The ADON further stated she would ask the medical record to locate the consents.On 8/7/25 at 4:15 P.M., an interview was conducted with the RP. The RP stated she could not recall any discussion with staff or clinicians about the purpose, risks, or benefits of Resident 7's psychotropic medications prior to Resident 7's medication administration. The RP further stated she signed the informed consent today [8/7/25].On 8/8/25 at 9:52 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 3. LN 3 stated that there was no informed consent for the Brexpiprazole, and the Quetiapine Fumarate was signed by the RP on 8/7/25. LN 3 further stated the informed consent should have been signed before giving the psychotropic medications to ensure the resident or RP was aware of the risks and benefits of the treatment, and the consent was the confirmation of the treatment.Per the facility's policy and procedure, dated 2/2025, titled Psychotropic Medication Use, .Informed Consent or Refusal 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining a documented consent .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify a resident and/or the resident's representative notices of transfer/discharge and bed hold for one of two residents reviewed for hospitalization. (Resident 45). This failure had the potential for the resident and/or the resident's representative not to have information regarding the transfer/discharge as well as bed hold rights.Findings:Resident 45 was re-admitted to the facility on [DATE] with diagnoses including displaced fracture of olecranon process (bony point of elbow) and dislocation of left shoulder joint according to the facility's admission Record.During an observation and interview on 8/5/25 at 9:15 A.M. with Resident 45, Resident 45 was observed sitting up in a wheelchair next to his bed. A floor mat was observed on the right side of the bed and Resident 45 had a dressing on the right arm close to the elbow. Resident 45 stated he had a fall in the facility in the middle of the night and sustained a skin tear on the elbow. A review of Resident 45's medical record in the electronic medical record (EMR) was conducted. A progress note (PN) dated 5/26/25 at 3 A.M. indicated staff heard moaning in Resident 45's room and found Resident 45 on the floor, face down on the right side. The PN indicated Resident 45 was transferred to the emergency room (ER)l at 5:45 A.M. and returned to the facility on 5/27/25 at 5:18 P.M. The PN further indicated staff received left shoulder x-ray result for Resident 45 on 5/28/25 at 7:02 P.M. and Resident 45 was sent out again to ER for a dislocated left shoulder. An interview was conducted on 8/6/25 at 2:24 P.M. with Licensed Nurse (LN) 4. LN 4 stated for emergency room transfers, the residents' emergency contact and transportation were contacted. LN 4 stated the resident's face sheet, medication list, preferred intensity of care (code status) and current orders were sent with the resident to the hospital. LN 4 stated a notice of transfer/discharge was also provided to the resident or the resident representative. LN 4 stated bed hold notification was completed by social services or admissions staff.During an interview on 8/6/25 at 3:15 P.M. with the Infection Preventionist (IP), the IP stated she checked Resident 45's medical records and notices regarding transfer/discharge and bed hold were not found for both 5/26/25 and 5/28/25 Resident 45's ER transfers.During an interview on 8/8/25 at 9:04 A.M. with LN 3, LN 3 stated it was important to provide residents and/or families with the notice of transfer and bed hold for families to be aware of residents' transfer and the reason. LN 3 stated bed hold notification was also needed for families not to worry about having a bed upon return from the hospital.An interview on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON) was conducted. The ADON stated the nursing staff was responsible for completing the Notification of Transfer/Discharge and Bed Hold forms. The ADON stated Resident 45 should have been provided with the forms per facility policy.A review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, dated 2001 was conducted. The P&P indicated, The resident and representative are notified in writing.The specific reason for the transfer or discharge.The effective date of the transfer or discharge.The specific location.An explanation of the resident's rights to appeal the transfer or discharge to the state.The Notice of Facility Bed-Hold and policies.The name, address, and telephone number of the Office of the State Long-term Care Ombudsman [patient advocate].The name, address, and telephone number of the state health department agency designated to handle appeals of transfers and discharges notices.

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	555362	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Las Campanas	18655 W. Bernardo Drive San Diego, CA 92127

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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 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** Based on observation, interview and record review, the facility failed to provide services to promote healing when a pressure injury (a wound caused by prolonged pressure) had developed for one of four sampled residents (Resident 3) when weekly wound assessments were not conducted and Resident 3's wound stages were not accurately assessed. These failures had the potential for Resident 3 to have delayed wound healing. Findings:A record review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy), functional quadriplegia (the inability to move all limbs due to severe disability or weakness), gastro-esophageal reflux disease (a condition in which stomach contents move up into the esophagus), and a history of falling. A record review of Resident 3's Minimum Data Set (MDS- a standardized comprehensive assessment of residents' health conditions, functional abilities, and care needs) report dated 7/9/25 indicated the resident's Brief Interview of Mental Status (BIMS- a cognitive screening test) score was 15, which indicated intact cognition. The MDS indicated Resident 3 was admitted without any pressure injuries.A record review of the Braden Scale for Predicting Pressure Sore Risk dated 4/5/25 indicated Resident 3 was at risk for developing a pressure injury. During a concurrent observation and interview on 8/5/25 at 8:50 A.M., Resident 3 was observed laying in bed on a low air low mattress. Resident 3 stated the facility provided the bed after he had sores on my bottom. Resident 3 stated he does not know how the sores developed.A record review of the facility's Progress Note dated 5/7/25 indicated, Resident assessed for 2 open wounds located on bilateral buttocks. Both wounds present with size 1cm [centimeter-unit of measurement] x 1cm, no drainage or odor noted.Resident requested to order low air loss mattress. A record review of the facility's Progress Note dated 5/8/25 indicated, Patient self responsible aware of new open areas to left and right buttock stage 1 [an area of redness caused by prolonged pressure to the skin] pressure wounds.A record review of the Skilled Charting dated 5/12/25 indicated Resident 3 had excoriation [scratch-like marks to the skin] to bilateral buttocks instead of pressure injuries to bilateral buttocks. On 8/8/25 at 8:20 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 3. LN 3 stated per facility protocol, residents with pressure injuries were seen by the Wound Specialist (Nurse Practitioner) during the weekly visits. LN 3 stated Resident 3's pressure injuries should have a weekly wound assessment that included measurements and response to treatment, but there was no weekly wound documentation in the chart. LN 3 stated she could not find documentation that the Wound Specialist or Physician had seen Resident 3's pressure injuries. LN 3 further stated since the wounds were open, they should have been documented as Stage 2 pressure injuries, not as Stage 1 or excoriation. On 8/8/25 at 10:04 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON acknowledged Resident 3 was at high risk for skin breakdown due to immobility and recent severe weight loss. The ADON stated Resident 3 should have been seen by the Wound Specialist during the weekly visit to assess the wounds and clarify the wound stages, to promote optimal healing.A record review of the facility's policy titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, revised 3/24, indicated, The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss.In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates [drainage] or necrotic tissue [dead tissues].

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive systematic approach to ensure effective monitoring to maintain acceptable parameters of nutritional status for 1 of 5 sampled Residents (Resident 3) when: 1. The facility did not follow their policy for change of condition (physical change-weight loss) when Resident 3 was not placed on weekly weights (measurement of body weight).2. The Registered Dietitian (RD) did not reassess Resident 3's weight loss to determine appropriate interventions.3. Resident 3's weight loss was not communicated to the physician.4. The Interdisciplinary Team (IDT- a team comprised of professionals from various disciplines who work in collaboration to address residents' needs) did not address the severe unplanned weight loss.5. Resident 3's care plan did not reflect the severe unplanned weight loss, and no interventions (an action taken to address Resident 3's weight loss) were implemented.As a result, Resident 3 experienced a severe, unplanned weight loss of 24.4 lbs. (pounds- a measurement of weight), 14.77% from weights obtained from 4/5/25 to 8/6/25. Resident 3 was at risk to experience medical complications including but not limited to dehydration, loss of muscle mass with decreased mobility, and negatively affect Resident 3's health and well-being, which could include death.Findings:A record review of Resident 3's admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy), functional quadriplegia (the inability to move all four limbs due to severe disability or weakness), gastro-esophageal reflux disease (a condition in which stomach contents move up into the esophagus), and a history of falling.A record review of Resident 3's Minimum Data Set (MDS- a standardized comprehensive assessment of residents' health conditions, functional abilities, and care needs) report dated 7/9/25 indicated the resident's brief interview of mental status (BIMS- a cognitive screening test) score was 15, which indicated intact cognition.On 8/5/25 at 8:50 A.M., a joint observation and interview was conducted with Resident 3 in his room. Resident 3 was in bed and had his breakfast tray in front of him. Resident 3 had eaten most of his breakfast. Resident 3 stated he liked breakfast, but lunch and dinner were .hit or miss. I'll ask for a sandwich if I don't like the food. Resident 3 stated, I didn't care for the food the last couple of weeks. and that he had recently lost weight. Resident 3 stated he received a [Nutrition Shake] (meal or snack replacement designed for diabetic patients) with every meal. Resident 3 stated he consumed the entire bottle of the nutritional supplement during breakfast. Resident 3 stated he rarely consumed the full amount of the nutritional shake for lunch and dinner, .sometimes I drink a third, sometimes half, sometimes less. It depends on. Resident 3 stated he weighed about 170 pounds prior to admission to the facility, and now weighed about 140 lbs. Resident 3 stated he would not like to lose any more weight because he did not want his clothes to fit too loosely. Resident 3 stated he did not know the reason he had lost weight, and he had not planned to lose weight.On 8/5/25 at 8:59 A.M., an interview was conducted with Resident 77 (Resident 3's wife and current roommate). Resident 77. Resident 77 stated that Resident 3 would often choose food options from an alternative menu. Resident 77 stated, .my husband is losing weight. He tries to give me his chips sometimes and I tell him he needs to eat it, so he doesn't lose anymore weight.A record review of Resident 3's Weight Summary dated 8/6/25 indicated:4/5/25 165.2 lbs. (pounds-measurement of weight).5/4/25 153.6 lbs.5/10/25 150.6 lbs.5/22/25 147.2 lbs.6/2/25 146.6 lbs.6/19/25 147.6 lbs.7/1/25 148.1 lbs.8/1/25 140.0 lbs.8/6/25 140.8 lbs.Resident 3 experienced a 17.1 lb., 10.35% severe weight loss in ninety days or 3 months, from 4/5/25 to 7/1/25.On 8/6/25 a record review of Resident 3's Nutrition Evaluation dated 4/7/25 was conducted. The Nutrition Evaluation was completed by the Registered Dietitian and indicated Resident 3's usual body weight was between 170-175 lbs. The Nutrition Evaluation indicated Resident 3 was not on a planned weight change program. The Nutrition Evaluation further indicated, .Seen during lunch, reports poor intake x 1.5 weeks.Goal to remain weight stable through recovery. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mod [moderate] nutrition risk per poor intake, recent wt. [weight] loss.Nutrition Monitoring: Monitor intake, weight, evaluate labs when available. Will adjust nutrition POC [Plan of Care] as indicated.On 8/6/25 a record review of Resident 3's Nutrition Evaluation dated 7/7/25 was conducted. Per the Nutrition Evaluation document. Describe any recent weight changes.currently weight stable x 2 months weight loss -17.1# (10.4%) over the first month of admission 3 months ago. [Resident 3] is at potential risk for weight loss, dehydration, and malnutrition r/t [related to] variable PO [oral-by mouth] intake and recent wt. [weight] loss trend. There were no new interventions or recommendations indicated in the Nutrition Evaluation. LN3 and RD verified there was no documentation related to interventions for Resident 3's weight loss. On 8/6/25 at 12:52 P.M., an interview was conducted with the Restorative Nursing Assistant 1 (RNA-Certified Nurse Assistant who work alongside rehabilitation staff to provide exercises for residents with limited mobility). RNA 1 stated she was responsible for obtaining residents' weights. RNA 1 stated newly admitted residents were weighed the day after admission, then once a week for the first four weeks. RNA 1 stated a list of any significant weight changes were provided to the Director of Nursing (DON) and/or the charge nurse. RNA 1 stated, .the Registered Dietitian (RD) doesn't need a copy of the weights because she can read it in [the Electronic Health Record]. RNA 1 stated she had not attended any IDT weight meetings. RNA 1 stated she was aware that Resident 3 had been losing weight and had been refusing RNA exercises because Resident 3 was too tired. On 8/7/25 at 9:56 A.M., a joint interview and record review of Resident 3's facility chart was conducted with Licensed Nurse (LN) 3. LN 3 stated, A significant weight loss is considered a change of condition (COC) because [the weight loss] is not normal for the patient, if [the weight loss] was not planned we need to figure out why it's happening and to implement new interventions to take care of the resident. LN 3 stated there was not a COC completed to address Resident 3's weight loss and to notify the physician. LN3 stated, I did not see a COC in Resident 3's EHR. LN 3 stated Resident 3's care plan should have been updated to reflect the weight loss. LN 3 further stated [Nutritional shake] was not listed in Resident 3's Physician's Orders, and there was no documentation of the amount of the nutritional shake consumed. LN 3 stated it was important to document the amount of [Nutritional shake] consumed by Resident 3 to ensure he was receiving enough calories. On 8/7/25 at 2:12 P.M., a joint interview and review of Resident 3's facility medical record was conducted with the Dietary Manager (DM) 1. DM 1 stated she was responsible for obtaining residents' food preferences upon admission, and updated preferences when there were changes in the residents' condition, such as weight loss. DM 1 stated Resident 3 usually asked for a sandwich for lunch, instead of the standard menu items. DM 1 stated Resident 3 typically ate lunch in the dining room, but lately he had been eating in his room. DM 1 stated I noticed [Resident 3] is only eating half of his sandwiches for lunch. DM 1 stated currently he gets [Nutritional shake] three times a day. DM 1 stated she was not sure if Resident 3 was consuming all of the [Nutritional shake] because there was no recording of the amount of the [Nutritional shake] consumed by Resident 3. DM 1 stated she knew Resident 3 should have had a nutritional shake because the RD had recommended a nutritional shake.On 8/7/25 at 2:49 P.M., a telephone interview was conducted with the Registered Dietitian (RD). The RD stated it was important that residents were weighed weekly upon admission, to see any significant trends.if there's pertinent wounds or conditions that require more calories or nutrition. It's critical to see the weight trend for that month.to give us a good foundation to see if they're eating enough. The RD stated, [Resident 3] wasn't trying to lose weight, but it was acceptable to him. The weight loss is not acceptable to me because it does impact his nutritional status and can lead to malnutrition, and to recover and stay well. In addition, the RD stated, [Resident 3] will be prone to muscle weakness and skin breakdown.gaining weight would improve his quality of life. The RD stated an IDT note to address Resident 3's weight loss should have been in Resident 3's medical records.On 8/8/25 at 1:04 P.M., a telephone interview was conducted with the Medical Director (MD). The MD stated his expectation was for any significant or severe weight loss to be addressed during the IDT meeting. The MD stated he expected weight loss interventions to be (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented. The MD stated, We don't want [Resident 3] to decline, have skin breakdown.a lot of things could happen for this resident such as major physical decline due to weight loss and this could have been easily addressed.During a record review on 8/8/25 the facility's policy titled Weight Management revised 10/24, the policy indicated, Significant weight changes (>/=2% in one week or >/=5% in one month) must be noted on the weekly report forms and reported to the attending physician by the licensed nurse.Residents who have been deemed as having significant weight loss or gain will be assessed by the Registered Dietitian for dietary changes and recommendations.The attending physician will be informed of all significant weight loss and gain.During a record review on 8/8/25 of the facility's policy titled Nutritional Assessment revised 10/17, the policy indicated, The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission.and as indicated by a change in condition that places the resident at risk for impaired nutrition.Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications.During a record review on 8/8/25 of the facility's policy titled Weight Assessment and Intervention revised 3/22, the policy indicated, The threshold for significant unplanned and undesired weight loss will be based on the following criteria:.1 month- 5% weight loss is significant; greater than 5% is severe.3 months- 7.5% weight loss is significant; greater than 7.5% is severe.6 months- 10% weight loss is significant; greater than 10% is severe.According to a 2002 American Academy of Family Physicians Journal article, Involuntary weight loss can lead to muscle wasting, decreased immunocompetence, (the ability for the body to develop an immune response) depression and an increased rate of disease complications. Research has shown institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year. (www.aafp.org/afp)According to a literature review of the Academy of Nutrition & Dietetics, Nutrition Care Manual, dated 2022, .Unintended weight loss is linked to increased mortality (death) among older adults . residents in long-term-care facilities who continue losing weight have a higher mortality rate compared with those who stop losing weight. Weight loss of 5% or more within 30 days is associated with a tenfold increase in the likelihood of death . (https://www.nutritioncaremanual.org/).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer blood pressure medication for one of four residents reviewed for medication errors. (Resident 25)This failure has the potential to affect Resident 25's health and wellbeing. Findings:Resident 25 was re-admitted to the facility on [DATE] with diagnoses including hypertensive heart (heart condition caused by long-term high blood pressure) and chronic kidney disease according to the facility's admission Record.A medication observation was conducted on 8/7/25 at 11:23 A.M. with Licensed Nurse (LN) 2. LN 2 administered nine medications to Resident 25: bumetanide (increases urine production) 2 mg (milligrams), flecainide acetate (for irregular heart beat) 50 mg, famotidine (for stomach acid) 10 mg, vitamin C 500 mg, vitamin D3 25 mcg (microgram), multivitamin one tablet, fluticasone nasal (for allergies) spray 50 mcg, chewable aspirin 81 mg, and amlodipine (for blood pressure).A review of Resident 25's physician's orders was conducted. Resident 25's physician's orders included eleven medications which included a breathing treatment and metoprolol (blood pressure medication) 25 mg daily.A joint observation, interview and record review on 8/7/25 at 9:26 A.M. was conducted with LN 2. LN 2 reviewed Resident 25's physician's orders then checked the medication card for the metoprolol. LN 2 stated she missed giving Resident 25 his metoprolol. LN 2 stated she thought she had administered the medication.An interview on 8/8/25 at 10:30 A.M. with the Assistant Director of Nursing (ADON) was conducted. The ADON stated during medication administration, her expectation was for nursing staff to verify the resident, time, correct medication, route and dose. The ADON further stated staff should check physician's orders in the electronic medication administration record (EMAR) against the medication card and repeat the process to ensure all medications were administered according to physician's orders.A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019 was conducted. The P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration.