Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555424	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dorothy & Joseph Goldberg Healthcare Center	211 Saxony Road Encinitas, CA 92024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of 13 residents (Resident 151) had a physician ordered medication available to be administered. As a result, Resident 151 was not administered one of his medications for six days. Findings: A review of Resident 151's Admission Record indicated the resident was admitted to the facility on [DATE]. On 7/11/24 at 8:20 A.M., a medication administration observation was conducted with licensed nurse (LN) 3. LN 3 was observed preparing medications for Resident 151. LN 3 stated Resident 151's calcium carbonate with vitamin D 1250 milligrams-5 micrograms was not available for her to administer to the resident. A review of Resident 151's physician orders dated 7/5/24, indicated the resident was to receive calcium carbonated-vitamin D 500 mg tablet; 1250 milligram-5 micrograms once a day at 8 A.M. for the diagnosis of vitamin D deficiency. A review of Resident 151's medication administration record (MAR) indicated the resident's calcium carbonated-vitamin D 500 mg tablet; 1250 milligram-5 micrograms was Not administered: Drug/item unavailable on 7/6/24 through 7/11/24. On 7/11/24 at 1 P.M., an interview was conducted with LN 3. LN 3 stated she was unsure when to call the physician and notify them that a resident's medication was unavailable. On 7/11/24 at 1:02 P.M., an interview was conducted with LN 4. LN 4 stated by the third day, the resident's physician should be made aware that a medication had been unavailable to give to a resident. LN 4 stated the nurses should not have been continually documenting for six days that Resident 151's medication was unavailable without following up on it. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Dorothy & Joseph Goldberg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Saxony Road Encinitas, CA 92024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 2:10 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 151's calcium carbonated-vitamin D 500 mg tablet; 1250 milligram-5 micrograms was ordered upon the resident's admission (7/5/24) and should have been available from the facility's central supply. The DON stated the central supply had waited to order Resident 151's medication on 7/12/24 when ordering other supplies which was not an acceptable practice. The DON stated her expectation was for the admitting nurse to be familiar with the medications available in central supply and clarify with the physician any medications not readily available in the facility's supply. The DON stated the physician could then order something the facility carried or they could request the order be filled by the facility's pharmacy if the medication was not carried in facility stock. The DON stated Resident 151's medication should not have been unavailable to administer to the resident for six days. The DON further stated there was no documentation Resident 151's physician was notified about this unavailable medication. The DON stated the issue should have been followed up on and resolved. On 7/12/24 at 12:07 P.M., an interview was conducted with the DON. The DON stated the facility did not have a policy to guide the ordering and availability of medications available through central supply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Dorothy & Joseph Goldberg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Saxony Road Encinitas, CA 92024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to follow the prn (as needed) guidelines for psychotropic medications (medications which alters the mind) for one of five residents (Resident 33) selected for Medication Review, when: 1. A specific behavior was not documented, indicating the necessity of a prn psychotropic medication; and 2. The physician did not document a rationale for the continued use of a prn psychotropic medication beyond the 14-day limit. This failure had the potential for Resident 33 to have increased risk of side effects and a prolonged duration of use. Findings: 1 Resident 33 was admitted to the facility on [DATE], with diagnoses which included non-traumatic intracerebral hemorrhage (bleeding in the brain), per the facility's Resident Face Sheet. On 7/10/24 Resident 33's clinical record was viewed: According to the physician's order, dated 3/17/24, Lorazepam (a drug used to treat anxiety, which act on the brain and nerves), 0.5 milligrams (mg) give twice a day, by mouth, under the tongue as needed for anxiety and/or shortness of breath. Open Ended. The Medication Administration Record (MAR) was reviewed from June 1, 2024, through July 12, 2024. On the June 2024 MAR, nursing documented Lorazepam was administered four times. The documented reasons for administration were listed as: crying inconsolable, yelling out, anxiety with agitation as exhibited by screaming and anxiety manifested by screaming. On the July 2024 MAR nursing documented Lorazepam was administered once. The documented reasons was listed as: yelling out and restlessness. On 7/11/24 at 7:59 A.M., an interview was conducted with Licensed Nurse 10 (LN 10). LN 10 stated Resident 33 was removed from hospice (end of life care) on 3/8/24, and her medication regimen was continued. LN 10 stated psychotropic prn medications required a specific behavior to be exhibited before the medication could be administered. LN 10 stated Resident 33 exhibits the behavior of yelling out constantly, either calling out her son's name or yelling for help. On 7/12/24 at 8:28 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 33's physician listed a behavior of anxiety for the administration of prn Lorazepam, which was not a specific behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Dorothy & Joseph Goldberg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Saxony Road Encinitas, CA 92024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24 at 9:22 A.M., an interview was conducted with LN 11. LN 11 stated a behavior listed as anxiety was subjected and open to interpretation. LN 11 stated anxiety was a generalized behavior and not specific, such as attempting to get out of bed, excessive crying, or striking out at staff. LN 11 stated the documented behavior must be exhibited before administrating a prn psychotropic medication. LN 11 stated it was the physician's responsibility to list the specific behavior and it was the nurse's responsibility to ensure a specific behavior was listed. On 7/12/24 at 10:15 A.M., an interview and record review was conducted with the Minimum Data Set Nurse (MDSN). The MDSN stated she sat on the psychotropic review committee, which met every quarter. The MDSN reviewed Resident 33's order for Lorazepam prn and stated anxiety was not a specific behavior and was open to interpretation. The MDSN stated a specific behavior should be listed, so staff knew under what circumstances they should administer the medication. The MDSN stated psychotropic medications had the potential to cause serious side effects. According to the facility's policy, titled Antipsychotropic Medication Use, dated December 2016, .13. Residents will not receive a PRN dose of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record . 2. Resident 33 was admitted to the facility on [DATE], with diagnoses which included non-traumatic intracerebral hemorrhage (bleeding in the brain), per the facility's Resident Face Sheet. On 7/10/24 Resident 33's clinical record was viewed: According to the physician's order, dated 3/17/24, Lorazepam (a drug used to treat anxiety, which act on the brain and nerves), 0.5 milligrams (mg) give twice a day, by mouth, under the tongue as needed for anxiety and/or shortness of breath. Open Ended. On 7/11/24 at 7:59 A.M., an interview was conducted with LN 10. LN 10 stated prn psychotropic medications expired every 14-days. Once the medication expired, the physician was required to write a new order and to document in the progress notes why the medication was being renewed with a justification of its necessity. On 7/12/24 at 8:28 A.M., an interview was conducted with the DON. The DON stated she was aware the physician was required to write a justification when renewing a 14-day prn psychotropic medication. The DON stated she has informed all the physician's that this was a Federal requirement. The DON stated she does not believe Resident 33 had experienced any harm from the continued use of prn Lorazepam, but agreed they were not following the Federal regulation set by CMS (Centers for Medicare and Medicaid Service). On 7/12/24 at 10:05 A.M. a review of the facility's monthly Medication Regimen Review (MRR) binder was conducted. The consulting pharmacist (CP) made the following recommendations for Resident 33 in March and April 2024; The patient has orders for PRN Lorazepam. Please clarify a STOP DATE or if needed to continue beyond 14 days then the MD (Medical Doctor) needs to document the reason why in progress notes or on this letter. The March 2024 MRR contained a handwritten note from the physician which read may stop it, however the medication was continued. The April 2024 MRR contained no documentation from the MD. There were no recommendations made for May and June of 2024 from the CP, even though the prn Lorazepam was renewed every 14-days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dorothy & Joseph Goldberg Healthcare Center	211 Saxony Road Encinitas, CA 92024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24, Resident 33's physician progress notes were reviewed from May 2024 through July 2024. There was no documented evidence by the physician for the continued use or justification of prn Lorazepam. On 7/12/24 at 10:15 A.M., an interview and record review was conducted with the MDSN of Resident 33's MRR for March through June 2024. The MDSN stated she sat on the psychotropic review committee, which met every quarter. The MDSN stated the physician was required to document a justification each time a 14-day prn psychotropic medication was renewed. The MDSN reviewed Resident 33's MRR and stated the consulting pharmacist made the recommendation to discontinue the Lorazepam or else write the reason why it was renewed and required. The MDSN could not find any documentation in the MRR from Resident 33's physician indicating the prn psychotropic medication was justified for continued use. On 7/12/24 at 11:04 A.M., a voice message was left for Resident 33's physician asking for a return call. The physician did not return the call. On 7/12/24 at 1:51 P.M., an interview was conducted with the Consulting Pharmacist (CP). The CP stated Resident 33's prn psychotropic recommendations was based on the Federal requirement, which required the physician to provide a written justification for renewing the 14-day prn. The CP stated she noticed there was no written justification, so the recommendation was made to the physician. According to the facility' policy, titled Antipsychotropic Medication Use, dated December 2016, .14. The need to continue PRN orders for psychotropic medication beyond the 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 15. PRN orders for antipsychotropic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Dorothy & Joseph Goldberg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Saxony Road Encinitas, CA 92024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 39111 Based on interview and record review, the facility failed to ensure information in one of 13 resident's (Resident 3) medical/clinical record was readily accessible. As a result, it could not be determined if Resident 3 had been administered a controlled medication (medication with high potential for abuse). Findings: A review of Resident 3's Admission Record indicated the resident was readmitted to the facility on [DATE]. On 7/11/24 at 4 P.M., copies of Resident 3's physician's orders, medication administration record (MAR), and controlled drug record (CDR, a written record that tracked when a controlled medication was removed from supply) for the resident's lorazepam (a controlled medication) 0.5 milligram tablets was requested from the medical records director (MRD). The MRD confirmed the requested documents would be available by 8 A.M. the following day. On 7/12/24, Resident 3's lorazepam 0.5 mg order, MAR, and CDR were reviewed. Resident 3's CDR indicated the resident's lorazepam had been removed from supply on: 6/26/24 at 6 A.M. 6/27/24 at 6 A.M. 6/28/24 at 6 A.M. 6/29/24 at 6 A.M. 6/30/24 at 6 A.M. Resident 3's MAR did not reflect the resident had been administered the lorazepam 0.5 mg on 6/26/24 through 6/30/24 at 6 A.M. A review of Resident 3's physician orders indicated the resident's 6 A.M. dose of lorazepam 0.5 mg had been discontinued on 6/25/24. On 7/12/24 at 1 P.M., an interview was conducted with licensed nurse (LN) 11. LN 11 stated when administering a controlled medication to a resident, the LN had to sign the CDR and then sign off on the MAR to show that the resident received the medication. (continued on next page)

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dorothy & Joseph Goldberg Healthcare Center	211 Saxony Road Encinitas, CA 92024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24 at 1:08 P.M., an interview was conducted with the director of nursing (DON). The DON was notified that Resident 3's MAR did not reflect the administration of lorazepam 0.5 mg on 6/26/24 through 6/30/24 at 6 A.M. The DON stated she would review the resident's medical record for that documentation. On 7/12/24 at 2:10 P.M., an interview was conducted with the DON. The MRD was also present. The DON stated they were unable to retrieve the requested documentation from Resident 3's medical record. The DON stated this was not a medication diversion (when a controlled medication was unaccounted for and used for illegal purposes), but a matter of the resident's complete MAR being unavailable. The DON stated all of Resident 3's medical/clinical record should have been readily accessible and it was not. The DON acknowledged that because Resident 3's complete MAR was not accessible, it could not be determined if the resident had received her lorazepam. A review of the facility's policy titled Electronic Medical Records revised March 2014, did not provide guidance related to residents' medical records being readily accessible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Dorothy & Joseph Goldberg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Saxony Road Encinitas, CA 92024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure meal assistance provided to one sampled resident (Resident 3) was conducted in a sanitary manner when certified nursing assistant (CNA) 1 did not perform hand hygiene (washing hands or using an alcohol-based hand rub) after assisting another resident and did not wear gloves while feeding Resident 3 a sandwich using her bare hands. This deficient practice had the potential to spread microorganisms and to cause foodborne illness among residents. Findings: A review of Resident 3's Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses to include right sided weakness and paralysis following a stroke, difficulty swallowing, and was receiving palliative care (end of life). On 7/9/24 at 12:35 P.M., a lunchtime observation was conducted in the dining room designated for residents that required staff assistance to eat. CNA 1 was observed feeding Resident A, touching the resident's wheelchair, and adjusting the resident's clothing protector. CNA 1 then went to another table to help Resident 3. CNA 1 did not perform hand hygiene. Resident 3 was seated in her gerichair (specialized chair) with her eyes closed. CNA 1 held Resident 3's sandwich in her bare hand and fed it to the resident. Resident 3 consumed a couple bites of the sandwich. CNA 1 then went back to assisting Resident A, again without performing hand hygiene. On 7/11/24 at 1:15 P.M., an interview was conducted with CNA 2. CNA 2 stated it was unacceptable to touch a resident's food with bare hands. CNA 2 stated hand hygiene should have been performed and gloves donned. CNA 2 stated she would not have wanted to eat the sandwich that had been touched by a staff's bare hands. On 7/11/24 at 1:30 P.M., an interview was conducted with the facility's registered dietitian (RD). The RD stated Resident 3's health had declined, and the resident could no longer see. The RD stated Resident 3 was, Totally dependent on staff to feed her. The RD stated staff should not touch ready-to-eat food with bare hands. The RD stated her expectation was for CNA 1 to perform hand hygiene and don gloves before feeding the sandwich to Resident 3. On 7/12/24 at 8 A.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation for staff to perform hand hygiene and don gloves when assisting a resident to eat handheld food. On 7/12/24 at 9:30 A.M., an interview was conducted with the DON. The DON stated the facility did not have a policy to guide hand hygiene when providing feeding assistance to residents. On 7/12/24 at 9:46 A.M., an interview was conducted with CNA 1. CNA 1 stated she did not know that hand hygiene should be done and gloves worn when feeding a resident a ready-to-eat food. CNA 1 stated she did not receive that training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555424	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dorothy & Joseph Goldberg Healthcare Center	211 Saxony Road Encinitas, CA 92024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24 at 12:10 P.M., an interview was conducted with the director of staff development (DSD). The DSD stated he provided hand hygiene training to staff but did not specifically train related to hand hygiene when providing feeding assistance to residents. The DSD stated staff should be performing hand hygiene between residents and that gloves should be worn, after performing hand hygiene, if touching a resident's ready-to-eat food. The DSD stated bare hands should not be used to touch residents' food.