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	07/24/2025

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 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 interview and record review, the facility failed to verify if one of 15 sampled residents (Resident 39) had an advance directive. In addition, the facility did not provide written information to Resident 39 related to formulating an advance directive.As a result, this had the potential to affect Resident 39's care and treatment in the event the resident could not make decisions for himself.Findings:A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE].On 7/24/25 at 11:40 A.M., an interview and record review was conducted with the social services designee (SSD). The SSD stated it was her job to check if residents had an advance directive upon admission. This would then be discussed during the resident's first care conference. The SSD reviewed Resident 39's clinical record and stated there was no documentation the resident had an advance directive. The SSD stated she did not verify if Resident 39 had an advance directive. The SSD stated prior to being at the skilled nursing facility, Resident 39 lived in the independent living facility (ILF) and may have had an advance directive at the ILF. The SSD stated she would check.On 7/24/25 at 12:10 P.M., an interview was conducted with the SSD. The SSD stated Resident 39 did not have an advance directive on file at the ILF. The SSD stated she should have discussed having an advance directive with Resident 39.On 7/24/25 at 12:25 P.M., another interview was conducted with the SSD. The SSD stated Resident 39 should have been provided written information about formulating an advance directive and should have been informed of the facility's policies and procedures for advance directives.On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation for the SSD to check if residents had an advance directive upon admission and to provide them with written information related to formulating an advance directive.A review of the facility's policy titled Advance Directives revised December 2016, indicated, .1. Upon admission, the resident will be provided with written information concerning the right to.formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives.6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 8. If the resident indicates that he or she has not established advance directives, the facility will offer assistance in establishing advance directives.

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 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 interview and record review, the facility failed to provide written notice of transfer and written notice of bed-hold policy to one of four residents (Resident 7) reviewed for transfer and discharge.As a result, there was the potential for residents to be uninformed about their transfer and bed-hold rights when sent to the hospital.Findings:A review of Resident 7's Resident Face Sheet indicated the resident was readmitted on [DATE].A review of Resident 7's Resident Progress Notes dated 4/27/25, indicated the resident was transferred to the hospital for evaluation of a fever. Resident 7 was not sent via 911 services.A review of Resident 7's Resident Progress Notes dated 7/1/25, indicated the resident was transferred to the hospital for evaluation of a suspected urinary tract infection. Resident 7 was not sent via 911 services.On 7/23/25 at 12 P.M., an interview and record review was conducted with the director of staff development (DSD). The DSD reviewed Resident 7's clinical record and stated the resident was transferred to the hospital on 4/27/25 and 7/1/25. The DSD stated no written notice of bed-hold policy was provided to Resident 7 when transferred to the hospital. The DSD stated the facility did not provide written notices of bed-hold upon transfer to long-term residents. The DSD further stated there was no documentation of written notices of transfer provided to Resident 7. The DSD stated, We don't notify in writing when they're alert and it's a transfer.On 7/24/25 at 3:51 P.M., an interview was conducted with the DSD. The DSD stated the facility did not have a policy related to written notice of transfer.On 7/24/25 at 5:06 P.M., an interview was conducted with the director of nursing (DON). The DON acknowledged written notices of bed-hold policy and written notices of transfer were not provided to Resident 7 when transferred to the hospital on 4/27/25 and 7/1/25.A review of the facility's policy titled Bed-Holds and Return revised March 2017, indicated, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately code the Minimum Data Set assessment (MDS, a comprehensive assessment) for two of 18 residents (Resident 39, and Resident 51). This deficient practice had the potential to affect the residents by delaying resident care needs and provided inaccurate information to the Federal database.1. A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE]. On 7/21/25 at 3:45 P.M., an observation and interview was conducted with Resident 39. Resident 39 stated he was continent of urine but that nursing staff put a urinary catheter on him at night. Resident 39 stated he did not know why and that it was the nursing staff who decided to put a urinary catheter on him. On 7/22/25 at 8:12 A.M., an observation of Resident 39 was conducted. Resident 39 was lying in bed and he was utilizing a urinary catheter. The catheter was draining clear, yellow urine into a drainage bag. A review of Resident 39's MDS Assessment Section H- Bladder and Bowel dated 6/9/25, indicated .Z. None of the above. for any appliances used (internal or external urinary catheters). On 7/24/25 at 11:30 A.M., an interview and record review was conducted with the MDS coordinator (MDSC). The MDSC reviewed Resident 39's admission MDS assessment dated [DATE]. The MDSC stated her look-behind period for conducting Resident 39's bladder and bowel assessment was from 6/3/25 through 6/9/25. The MDSC stated Resident 39 did not use a urinary catheter at that time which was why the MDS assessment was coded as Z. None of the above. The MDSC then reviewed Resident 39's Resident Progress Notes dated 6/5/25 which indicated the resident was wearing a condom (external) urinary catheter. The MDSC stated there was no order for the external urinary catheter until 7/11/25. The MDSC stated if there had been an order during her look-back period, she would have captured and coded the MDS assessment for the use of the external catheter. The MDSC stated, It got missed. The MDSC stated Resident 39's MDS assessment Section H dated 6/9/25 was inaccurately coded. The MDSC stated Resident 39's MDS assessment should have been accurate. On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation for MDS assessments to be accurate as they were a reflection of care and treatment provided to residents. The DON stated Resident 39's external catheter should have been captured and coded correctly on the MDS assessment. A review of the facility's CMS's [Center for Medicare and Medicaid Services] RAI [Resident Assessment Instrument- an instruction manual to guide completion of the MDS] 3.0 Manual dated October 2024, indicated, .Definitions External Catheter Device attached to the shaft of the penis like a condom.that routes urine to a drainage bag.Steps for Assessment 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances. Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances were used in the past 7 days. 2. Resident 51 was admitted to the facility on [DATE] per the facility's Resident Face Sheet. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25, a record review of Resident 51's MDS dated [DATE], indicated Resident 51 was discharged to general acute care hospital (GACH) on 4/22/25. On 7/23/25, a record review of a Licensed Nurse (LN) Progress notes, dated 4/22/25, indicated Resident 51 was discharged to another skilled nursing facility (SNF). On 7/23/25 at 8:31 A.M., a joint record review of Resident 51's clinical record and an interview was conducted with Licensed Nurse (LN) 22. LN 22 stated Resident 51 was admitted to the facility on [DATE] and was discharged to another SNF on 4/22/25. LN 22 stated the MDS Coordinator (MDSC) was responsible for encoding the resident's discharge from the facility on the MDS assessment. On 7/23/25 at 8:51 A.M., a joint record review of Resident 51's clinical record and an interview was conducted with MDSC. The MDSC stated she was responsible for coding the MDS assessment of the residents when they were admitted and when they were discharged . The MDSC stated Resident 51's MDS should have been coded correctly to reflect the correct information provided to Centers for Medicare and Medicaid Services (CMS, a federal agency). MDSN stated, It was just a data entry error. On 7/24/25 at 3:36 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the MDSC to provide the correct coding of the MDS to ensure accurate information was relayed to CMS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan for one of 15 sampled residents (Resident 49) that addressed the resident's communication needs.This failure had the potential to impact the resident's quality of care and treatment. Cross reference F676.Findings: Resident 49 was admitted to the facility on [DATE] per the facility's Resident Face Sheet. A record review of Resident 49's Minimum Data Set assessment (MDS, a comprehensive assessment) Section A Identification Information, A1110 Language dated 7/13/25, indicated Resident 49's preferred language was a foreign language. Documentation on Section A Identification Information included .b. Do you need or want an interpreter to communicate with a doctor or health care staff . Answer - yes A record review of Resident 49's written care plans indicated there was no baseline care plan for language/communication preferences. On 7/21/2025 at 8:30 A.M., an interview and observation was conducted with Resident 49. Resident 49 spoke a foreign language only. The Infection Preventionist (IP) came into the room and stated if he wanted to communicate with Resident 49 he gets a foreign language speaking certified nursing assistant (CNA), housekeeper or charge nurse to translate. Resident 49 said some words in a foreign language and pointed to her left ear. The IP went to find someone to translate what Resident 49 was saying. There was a white board on the wall of Resident 49's room that had goals written in English on it. There was also a menu written in English posted on the white board. On 7/21/25 at 8:40 A.M., an interview was conducted with Licensed Nurse (LN) 36 in Resident 49's room. LN 36 stated she could translate because she speaks a little of Resident 49's foreign language. LN 36 stated there were no communication tools available to speak to Resident 49, such as a communication board (a tool that uses pictures, symbols, or text to help people express themselves) or a language translation line (a phone service that facilitates communication between individuals speaking different languages) to help staff communicate with a resident. LN 36 stated we would look for someone who spoke the same foreign language or call the family member (FM) when we need to communicate with Resident 49. On 7/21/2025 at 9:12 A.M., an interview with Resident 49's FM was conducted. The FM stated she translated English to the foreign language for Resident 49. The FM translated for Resident 49 who stated that she would like different items for breakfast as she had been getting cereal, fruit and milk every day for the past week despite her choices, which frustrated her. Resident 49's FM translated that Resident 49 stated that sometimes she did not understand what the staff were telling her. Resident 49 stated there were times when the facility did not provided a translator. Resident 49 stated to her FM that most of the time she was alone and she could not get her needs met. On 7/23/25 at 8:42 A.M., an interview was conducted with LN 2. LN 2 stated Resident 49 spoke a foreign language and did not speak English. LN 2 stated she did not speak the resident's foreign language but could ask simple questions. LN2 stated if medical terminology was required, she would get someone to speak to Resident 49 in her language, such as unit clerk or contact her supervisor to get a translator. LN 2 stated there was no language phone line for translation or communication board for use. LN 2 stated Resident 49's FM was usually here to translate, or she was called for assistance. LN 2 stated there was no care plan in place for language preference, but it was important especially if the FM or staff were not available for translation. On 7/23/25 at 9:20 A.M., an interview was conducted with LN 3. LN 3 stated there was no language line translation service or communication board for Resident 49 because the staff would go and find a translator if available. LN 3 stated there was no baseline care plan done related to language preference for Resident 49. On 7/24/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the care plan was expected to be developed within 24 hours of admission and language preference would be expected to be care planned if the resident did not speak English. The DON stated Resident 49's baseline care plan should have included what communication (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tools were preferred by the resident. The DON stated a communication board or language line translation service should have been utilized so the resident's needs were met. A review of the facility's Baseline Care Plan template, undated, indicated, .Baseline Care Plan: will identify my care needs, risks, strengths and goals for the first 48 hours

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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** Based on observation, interview, and record review, the facility failed to ensure two of 15 sampled residents (Resident 15 and 39) had resident-specific written care plans developed for:1.The use of an external urinary catheter (condom catheter) for Resident 39.2. Resident 15's medication administration preferences.As a result, there was the potential residents' needs would not be met.Findings: 1. A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses to include urinary tract infection (UTI). On 7/21/25 at 3:45 P.M., an observation and interview was conducted with Resident 39. Resident 39 stated he was continent of urine but that nursing staff put a urinary catheter on him at night. Resident 39 stated he did not know why and that it was the nursing staff who decided to put a urinary catheter on him. On 7/22/25 at 8:12 A.M., an observation of Resident 39 was conducted. Resident 39 was lying in bed and he was utilizing a urinary catheter. The catheter was draining clear, yellow urine into a drainage bag. On 7/23/25 at 4:10 P.M., an interview was conducted with certified nursing assistant (CNA) 34. CNA 34 stated he often provided care to Resident 39 and knew him well. CNA 34 stated Resident 39 was continent of bowel and bladder. CNA 34 stated Resident 39 could hold his urine and would let him know when it was time to take him to the bathroom. CNA 34 stated he was not sure why Resident 39 used an external catheter when he was continent, and that it may be the resident's preference to use one. On 7/24/25 at 8:30 A.M., an interview and record review was conducted with license nurse (LN) 35. LN 35 stated she was unsure if Resident 39 was continent or incontinent. LN 35 stated Resident 39 used an external catheter at night, and she was unsure why he did so. LN 35 reviewed Resident 39's written care plans and stated there should have been a written care plan that addressed the resident's use of an external catheter. LN 35 stated the care plan should include why Resident 35 used an external catheter, how long it was to be used, and monitoring of its use. On 7/24/25 at 8:40 A.M., an interview and record review was conducted with LN 36. LN 36 reviewed Resident 39's clinical record and stated the resident's use of an external catheter did not have a clear indication. LN 36 reviewed Resident 39's written care plans and stated the resident's use of an external catheter was not included in the care plan. On 7/24/25 at 10:30 A.M., an interview and record review was conducted with the director of staff development (DSD). The DSD reviewed Resident 39's clinical record and stated there was no order for the resident's external catheter until 7/11/25. The DSD stated Resident 39's progress note indicated the external catheter was in use on 6/5/25 and there was no order. The DSD further stated there was no plan of care related to Resident 39's use of the external catheter. The DSD stated there should have been a written care plan for the use of the external catheter, So we know how to use it and can monitor and evaluate it as an intervention. On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there should have been a care plan developed to include Resident 39's use of an external urinary catheter. 2. A review of Resident 15's Face Sheet indicated the resident was admitted to the facility on [DATE] with a diagnosis of essential hypertension (high blood pressure) and displaced intertrochanteric fracture of left femur (a break in the bone of the left leg). A review of Resident 15's physician orders, dated 3/31/25, indicated medication orders for Labetalol (a medication for high blood pressure) 50 milligrams (mg), Metamucil 3 in 1 Daily Fiber 2 capsules, Daily Multivitamin 1 tablet, Valsartan (a medication for high blood pressure) 80 mg, Vitamin B-12 1,000 micrograms (mcg), and Vitamin D3 125 mcg to be administered at 8:00 A.M. On 7/23/25 at 9:49 A.M., an observation and interview was conducted with Licensed Nurse (LN 11) during Resident 15's medication administration. LN 11 administered Labetalol and Valsartan to Resident 15. LN 11 stated Resident 15 preferred to take her blood pressure medication separate from her other morning medications. LN 11 stated she would give the rest of Resident 15's morning medications around 10:45 A.M. On 7/23/25 at 11:02 A.M., an observation and interview was conducted with LN 11 during Resident 15's medication administration. LN 11 administered daily multivitamin, Vitamin B-12, and Vitamin D3 to Resident 15. Resident 15 stated she did not want to take the Metamucil capsules yet and requested LN 11 to come back in 15 minutes to give it to her. On 7/23/25 at 11:25 A.M., an observation and interview was conducted with LN 11 during Resident 15's medication administration. LN 11 administered Metamucil capsules to Resident 15. LN 11 stated Resident 15's medication administration for morning medications was scheduled for 8 A.M. and medications were considered late if given after 9 A.M. LN 11 stated there should have been a written care plan for medication administration preferences for Resident 15. On 7/24/25 at 8:25 A.M., an interview and joint record review was conducted with LN 36. LN 36 reviewed Resident 15's care plans and stated there was no care plan found for the resident's medication administration preferences. LN 36 stated Resident 15 should have had a specific person-centered care plan related to her medication administration preferences. On 7/24/25 at 4:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 15's morning medication should not have been given past 9 A.M. The DON stated Resident 15 should have had a person-centered care plan developed for a later medication administration time if the resident did not want to take her medications by 9 A.M. A review of the facility's policy titled Administering Medications, revised December 2012, indicated, .3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised December 2016, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.10. Identify problem areas and their causes, and developing interventions that are targeted and meaningful to the resident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary language services for one of 15 sampled residents (Resident 49).As a result, there was the potential for miscommunication to impact the resident's care and quality of life. Cross reference F655.Findings:Resident 49 was admitted to the facility on [DATE] per the facility's Resident Face Sheet. A record review of Resident 49's Minimum Data Set assessment (MDS - a comprehensive assessment) Section A Identification Information, A1110 Language dated 7/13/25 indicated Resident 49's preferred language was a foreign language. Documentation on Section A Identification Information included .b. Do you need or want an interpreter to communicate with a doctor or health care staff? Answer - yes On 7/21/2025 at 8:30 A.M., an interview and observation was conducted with Resident 49. Resident 49 only spoke a foreign language. The Infection Preventionist (IP) came into the room and stated if he wanted to communicate with Resident 49 he got a foreign language speaking CNA (certified nursing assistant), housekeeper or charge nurse to translate. Resident 49 said some words in a foreign language and pointed to her left ear. The IP went to find someone to translate what Resident 49 was saying. There was a white board on the wall of Resident 49's room that had goals written in English on it. There was also a menu written in English posted on the white board. On 7/21/25 at 8:40 A.M., an interview was conducted with Licensed Nurse (LN) 36 in Resident 49's room. LN 36 stated there were no communication tools available to speak to Resident 49, such as a communication board (a tool that uses pictures, symbols, or text to help people express themselves) or a language translation line (a phone service that facilitates communication between individuals speaking different languages) to help staff communicate with a resident. LN 36 stated we look for someone who spoke the same foreign language or call the family member (FM) when we need to communicate with Resident 49 .On 7/21/2025 at 9:12 A.M., an interview with Resident 49's FM was conducted. The FM stated she translated English to the foreign language for Resident 49. The FM translated for Resident 49 who stated that she would like different items for breakfast as she had been getting cereal, fruit and milk every day for the past week despite her choices, which frustrated her. Resident 49's FM translated that Resident 49 stated that she did not understand what the staff were telling her. Resident 49 stated there were times when the facility did not provide a translator. Resident 49 stated to her FM that most of the time she was alone, and she could not get her needs met. On 7/23/25 at 8:42 A.M., an interview was conducted with LN 2. LN 2 stated Resident 49 spoke a foreign language and did not speak English. LN 2 stated she did not speak the resident's foreign language but could ask simple questions. LN2 stated if medical terminology was required, she would have to get someone to speak to Resident 49 in her language, such as unit clerk or contact her supervisor to get a translator. LN 2 stated there was no language phone line for translation or communication board for use. LN 2 stated she would call the FM to translate for Resident 49.On 7/23/25 at 9:20 A.M., an interview was conducted with LN 3. LN 3 stated if available, she would get staff to translate to Resident 49 so she could communicate with Resident 49. LN 3 stated there was no language line translation service or communication board because the staff would go and find a translator if available. On 7/23/25 at 9:38 A.M., an interview was conducted with CNA 4. CNA 4 stated Resident 49 was a foreign language speaker. CNA 4 stated he could speak a little of Resident's 49 foreign language and stated he was able to kind of communicate with the resident. CNA 4 stated flash cards would be a helpful way for Resident 49 to communicate. CNA 4 also stated a phone translation line or ipad would be helpful for translation if the facility had that. On 7/24/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated they should have used communication tools that that Resident 49 preferred. The DON stated staff should utilized a communication board or language line translation service when communicating with the resident to (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure the resident's needs were met. The DON stated there was a language translation line service available and was surprised that her staff were not aware of the language service tool. The DON stated it was her expectation that the staff use the language line translation service when speaking to a non-English speaking resident. A review of the facility's policy titled Translation and/or Interpretation of Facility Services, revised May 2017, indicated, .11. Competent oral translation of vital information that is not available in written translation . shall be provided in a timely manner . c. Contracted interpreter service; e. Telephone interpretation service .13. Family members and friends shall not be relied upon to provide interpretation services for the resident

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently provide restorative nursing assistant (RNA , a staff who focuses on maintaining and improving resident's functional abilities) services for one of one sampled resident (Resident 32) reviewed for decreased range of motion (ROM, refers to how far one can move a joint or a body part, like an arm or leg, in different directions). This failure had the potential to cause contractures (stiffening of muscles), decreased ROM, and decreased mobility.Findings: Resident 32 was admitted to the facility on [DATE], with diagnosis which included stroke and quadriplegia (paralysis below the neck that affects all of a person's limbs), as per the facility's Resident Face Sheet. Resident 32's History and Physical (H&P,) dated 4/24/25, indicated Resident 32 did not have the capacity to make decisions. Per the H&P, Resident 32 was dependent on the facility staff on her activities of daily living (ADLs, basic tasks a person does to take care of oneself, like eating). A review of Resident 32's minimum data set (MDS- a federally mandated resident assessment tool), dated 6/6/25 indicated Resident 32 had functional limitations in ROM on her upper and lower extremities and that Resident 32 was dependent on staff. A review of Resident 32's physician orders dated 3/1/24 and 8/30/24 indicated the following:- RNA Training program for PROM to prevent bilateral knee contractures three times a week.- RNA to provide Passive ROM (PROM, a staff does the ROM to the resident) to the right upper arm extremities three times a week as tolerated. On 7/21/25 at 9:43 A.M., an observation of Resident 32 was conducted in her room. Resident 32's upper extremities were exposed. Resident 32 did not respond when her name was called. Resident 32's right hand was observed to be in a closed fist with her right thumb extended. On 7/22/25 at 3:40 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 22. CNA 22 stated he was familiar with Resident 32. CNA 22 stated Resident 32 had right side body weakness and was on RNA. CNA 22 stated Resident 32 was dependent on staff for her ADLs. CNA 22 stated he did not see RNA treatment in the afternoon shifts. On 7/23/25 at 9:47 A.M., a concurrent review of Resident 32' clinical record and an interview was conducted with RNA 22. RNA 22 stated Resident 32 had right side body weakness and was scheduled to receive PROM of her upper and lower extremities three times a week. RNA 22 stated Resident 32's RNA treatment was scheduled in the morning shift on Tuesdays, Thursdays and Saturdays. RNA 22 stated the RNAs documented the amount of time and the resident's response to treatment when Resident 32 received her RNA treatment. On 7/23/25, a review of Resident 32's RNA treatment program from 6/1/25 to 7/24/25 was conducted. The treatment record indicated Resident 32 missed seven treatments in June 2025 (6/5, 6/12, 6/14, 6/17, 6/19, 6/26 and 6/28) and five treatments in July 2025 (7/3, 7/5, 7/8, 7/14, and 7/19). On 7/24/25 at 10:20 A.M., a follow- up interview was conducted with RNA 22. RNA 22 stated Resident 32 refused RNA services on some days. RNA 22 stated when the residents missed their RNA services, the RNAs responsibility was to document in the resident's clinical record as refused. RNA 22 stated she did not know why Resident 32 missed some days of RNA services. On 7/24/25 at 10:27 A.M., a joint review of Resident 32's clinical record and an interview was conducted with Licensed Nurse (LN) 36. LN 36 stated there was missing documentation of RNA services to Resident 32 from June 2025 to July 2025. LN 36 stated there was no documentation as to whether Resident 32 received or refused the RNA services on those service dates. LN 36 stated the RNAs should have documented RNA services provided to Resident 32 to ensure the physician's orders were carried out as prescribed, to prevent Resident 32 from developing contractures and keeping her mobility as possible. On 7/24/25 at 3:36 P.M., an interview was conducted with the Director of Nursing. The DON stated the expectation was for the staff to follow the physician's RNA order to Resident 32 to prevent the resident from developing contractures, maintaining her functions and her joints' ROM. A review of the facility's policy titled Restorative Nursing Services, revised 7/17, indicated, Residents will receive restorative (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing care.to help promote optimal safety and independence.5. Restorative goals may include, but are not limited to supporting and assisting the resident in.b. Developing, maintaining and strengthening his/ her physiological.resources.

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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** Based on observation, interview, and record review, the facility failed to ensure one of 15 residents (Resident 39) reviewed for urinary incontinence, was:1. Evaluated and reassessed to determine if bladder continence or incontinence was present through an incontinence/bladder management program.2. Provided scheduled two-hour toileting based on the initial bladder assessment.3. Had a clear indication for the use of an external catheter (condom catheter) at night.These failures had the potential for Resident 39 to miss the opportunity to regain urinary continence through bladder retraining. In addition, this had the potential for the resident to develop urinary tract infections (UTI).Findings:A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses to include UTI.On 7/21/25 at 3:45 P.M., an observation and interview was conducted with Resident 39. Resident 39 stated he was continent of urine but that nursing staff put a urinary catheter on him at night. Resident 39 stated he did not know why and that it was the nursing staff who decided to put a urinary catheter on him.On 7/22/25 at 8:12 A.M., an observation of Resident 39 was conducted. Resident 39 was lying in bed and he was utilizing a urinary catheter. The catheter was draining clear, yellow urine into a drainage bag.On 7/23/25 at 4:10 P.M., an interview was conducted with certified nursing assistant (CNA) 34. CNA 34 stated he often provided care to Resident 39 and knew him well. CNA 34 stated Resident 39 was continent of bowel and bladder. CNA 34 stated Resident 39 could hold his urine and would let him know when it was time to take him to the bathroom. CNA 34 stated he was not sure why Resident 39 used an external catheter when he was continent, and that it may be the resident's preference to use one.On 7/24/25 at 8:30 A.M., an interview was conducted with license nurse (LN) 35. LN 35 stated she was unsure if Resident 39 was continent or incontinent. LN 35 stated Resident 39 used an external catheter at night, and she was unsure why he did so.On 7/24/25 at 8:40 A.M., an interview and record review was conducted with LN 36. LN 36 reviewed Resident 39's admission assessment dated [DATE] and stated the resident was identified as incontinent based on hospital documentation. LN 36 stated Resident 39 was documented by CNAs as continent in the daytime and incontinent at night when using the external catheter. LN 36 stated there was no documentation the facility followed up on Resident 39's bladder assessment and implemented a bladder program to determine if the resident was truly continent or incontinent.A review of Resident 39's Minimum Data Set Assessment (MDS, a comprehensive assessment) Section H- Bladder and Bowel dated 6/9/25, indicated, the resident was occasionally incontinent. The MDS also indicated, Has a trial of toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry since urinary incontinence was noted in this facility? The MDS was coded as Yes. The MDS further indicated, Response- What was the resident's response to the trial program? The MDS was coded, Unable to determine or trial in progress.On 7/24/25 at 10:15 A.M., an interview was conducted with the MDS Coordinator (MDSC). The MDSC reviewed Resident 39's clinical record and stated everyone admitted to the facility received a toileting program for 14 days to determine incontinence or continence. The MDSC stated there was no documentation the toileting program was implemented for Resident 39 or what the results of it were.On 7/24/25 at 10:30 A.M., an interview and record review was conducted with the director of staff development (DSD). The DSD reviewed Resident 39's clinical record and stated the resident was on a 14-day bowel and bladder assessment upon admission that required the resident to be toileted every two hours. The DSD stated there was no documentation in the electronic medical record that the bladder program had been done. The DSD stated CNAs were to record the two-hour toileting on a paper Intake and Output form that was located in Resident 39's bathroom.At 10:40 A.M., the DSD went to Resident 39's bathroom. There was no paper documentation/ Intake and Output form present.At 10:42 A.M., The DSD went to the medical records (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	director and asked for Resident 39's paper Intake and Output documentation of two-hour toileting during his 14-day bladder training. The medical records director told the DSD, [she's] never seen anything like that.The DSD stated the bowel and bladder management program should assess the resident over 14 days with every two-hours offering of toileting. The DSD stated this program should then be reassessed and reviewed to determine if the resident was incontinent or not and then develop an appropriate plan of care. The DSD stated nursing should have gone back and evaluated the bladder program for Resident 39. The DSD stated there was no follow through on Resident 39's initial bladder assessment. The DSD stated there was no documentation related to the bladder training that had been done for Resident 39 and that we should know if the resident was continent or incontinent.The DSD reviewed Resident 39's clinical record and stated there was no physician order for the external catheter until 7/11/25. The DSD stated Resident 39's progress note indicated the external catheter was in use on 6/5/25 and there was no order. The DSD further stated there was no plan of care related to Resident 39's use of the external catheter.On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated there should have been documentation of Resident 39's bladder program being done during the first 14 days of admission. The DON stated there should have been documentation of two hour toileting being offered to the resident. The DON stated the data obtained from the bladder program should have been reviewed to determine if the resident was continent or not.A review of the facility's policy titled Urinary Incontinence-Clinical Protocol revised April 2018, indicated, .4. As appropriate based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. Monitoring 1. The staff and physician will review the progress of individuals with impaired continence until continence is restored or improved as much as possible, or it is identified that further improvement is unlikely. a. This should include documentation of a resident's responses to attempted interventions such as scheduled toileting, prompted voiding, or medications used to treat incontinence.

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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** Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services were provided for two residents (Resident 7 and 34) according to acceptable standards of practice when:1.Licensed nurse (LN) 11 did not follow the prescription label and gave Resident 34's levofloxacin (antibiotic) with calcium which was contraindicated.2.Resident 7's controlled drug record (CDR) for oxycodone (controlled pain medication) did not reconcile with the medication administration record (MAR).As a result there was the potential for Resident 34 to experience the adverse effect of not receiving the intended antibiotic dosage. In addition, there was the potential for Resident 7's controlled drug to be diverted (when a medication is taken for use by someone other than whom it is prescribed). Findings:1. A review of Resident 34's Face Sheet indicated the resident was admitted to the facility on [DATE] with a diagnosis of Vitamin deficiency, local infection of the skin and subcutaneous (under the skin) tissue, and urinary tract infection.A review of Resident 34's physician orders, dated 7/21/25, indicated Levofloxacin tablet 500 milligrams (mg) was to be given once a day at 8 A.M. Resident 34's physician orders, dated 3/19/25, indicated Oyster Shell Calcium (calcium carbonate) 500 mg 2 tablets was to be given once a day at 8 A.M.On 7/23/25 at 8:22 A.M., an observation was conducted during Resident 34's medication administration. Licensed Nurse (LN) 11 was observed preparing Resident 34's morning medications. Resident 34's Levofloxacin medication label was observed to have a warning that indicated, give 2 hrs before antiacids (medication containing calcium carbonate), multivitamins, minerals, and iron. At 8:37 A.M., LN 11 administered Levofloxacin and Oyster shell calcium together to Resident 34.On 7/23/25 at 11:30 A.M., an interview and record review was conducted with LN 11. LN 11 reviewed the warning label on Resident 34's Levofloxacin and stated she should not have given Resident 34's calcium with it because it could have interfered with the effectiveness of the Levofloxacin.On 7/24/25 at 2:49 P.M., a telephone interview was conducted with the facility's pharmacist consultant (PC). The PC stated the warning label on Resident 34's levofloxacin package should have been followed. The PC stated the levofloxacin should not have been given at the same time as calcium. The PC stated, It affects the absorption of the antibiotic, and it was considered a medication error. A review of the facility's policy titled Administering Medications, revised December 2012, indicated, .7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.2. A review of Resident 7's Face Sheet indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of Crohn's disease (a disease that causes painful inflammation of the digestive tract) and chronic pain syndrome.A review of Resident 7's physician orders, dated 5/1/25, indicated Oxycodone 15 mg one tablet for severe pain as needed every eight hours.A review of Resident 7's CDR for Oxycodone 15mg tab, indicated the resident received the medication on 5/24/25 at 12 A.M. and 6/1/25 at 9 A.M.A review of Resident 7's May through July 2025 MAR for Oxycodone 15mg tab indicated the resident received the medication on 5/24/25 at 7:37 A.M. On 6/1/25 there was no documentation that Resident 7 received Oxycodone. On 7/18/25 at 7:18 A.M. documentation was created for Resident 7's oxycodone administration on 5/24/25 and indicated, .Late Administration: Charted Late, Comment: done on time - Given @ 12A [A.M.].On 7/24/25 at 4:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated LN 11 should have read the warning label for Resident 34's Levofloxacin and should not have given it with the calcium. The DON reviewed Resident 7's CDR and MAR for Oxycodone and stated the MAR and CDR do not match and documentation was missing for 6/1/25 on the MAR. The DON stated the nurse should not have documented on 7/18/25 for the 5/24/25 administration of Resident 7's Oxycodone and the nurse would not have known what they did two months ago.A review of the facility's policy titled Controlled (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Substances, revised December 2012, indicated, .an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance.This record must contain:.i. Time of administration.10. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties, and shall give the Administrator a written report of such findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its pharmacist consultant (PC) identified medication irregularities during the monthly medication regimen review (MRR) for two sampled residents (Resident 33 and 39).As a result, there was the potential for residents to receive medications with inappropriate duration and in excessive dosages. Cross reference F757. 1.A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses to include urinary tract infection (UTI). A review of Resident 39's History and Physical dated 6/6/25, indicated the resident was in the hospital from [DATE] through 6/3/25, and .For presumed urinary tract infection, the patient was treated with Rocephin [antibiotic].The patient's Rocephin was completed after a 5-day course on 6/1/25 and the patient was restarted on penicillin [antibiotic]. It was suspected that the patient had osteomyelitis [bone infection] of the left second toe. The patient's urine culture on May 27, 2025 showed over 100,000 colony- forming units of Klebsiella pneumoniae [type of bacteria] which was resistant to ampicillin, cefazolin, and cefuroxime [types of antibiotics] but susceptible to Rocephin, ceftazidime, Augmentin, ciprofloxacin and Bactrim [types of antibiotics]. The patient is currently asymptomatic. A review of Resident 39's physician order dated 6/3/25, indicated the resident was to receive penicillin tablet 500 milligrams twice a day, .No end date at this time.Dx [diagnosis] urinary tract infection, site not specified. A review of Resident 39's MAR for June and July 2025 indicated the resident received the penicillin as ordered. A review of Resident 39's Resident Census indicated the resident was discharged from the facility on 7/3/23 and was admitted on [DATE]. 2.A review of Resident 33's Resident Face Sheet indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of Unspecified dementia (a disease affecting cognition and memory), severe, with agitation. A review of Resident 33's physician orders, dated 6/13/25, indicated an order for nitrofurantoin macrocrystal (antibiotic) 100 milligrams (mg) one capsule once a day for UTI Prophylaxis with no stop date. A review of Resident 33's medication administration record (MAR) from 6/14/25 through 7/23/25, indicated the resident received nitrofurantoin daily. A review of the facility's Medication Regimen Review document titled Consultant Pharmacist's Medication Regimen Review Listing of Residents Reviewed with No Recommendations For Recommendations Created Between 6/1/25 And 6/24/25, indicated that Resident 33 and Resident 39's medications were reviewed by the facility's PC and did not require any recommendations. On 7/24/25 at 2:38 P.M., an interview and record review was conducted with the Infection Preventionist (IP). The IP reviewed the facility's MRR for 6/1/25 through 6/24/25 and stated (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 33 and Resident 39 did not have any medication recommendations. The IP stated Resident 33's nitrofurantoin did not have a stop date and the indication for use was UTI prophylaxis. The IP stated Resident 33 and Resident 39's antibiotics should have had a stop date because prolonged duration of antibiotics without a proper indication can contribute to antibiotic resistance (when bacteria or other microorganisms evolve to become resistant to the drugs designed to kill them). On 7/24/25 at 2:24 P.M., a telephone interview was conducted with the facility's PC. The PC stated for residents to continue taking antibiotics without a stop date, there should be a valid reason from the MD documented in the residents' clinical record. The PC stated antibiotics given without a stop date could be an unnecessary medications and lead to antibiotic resistance. The PC reviewed Resident 33's nitrofurantoin and stated she completed the resident's MRR on 6/23/25 and stated it should have had a stop date. The PC stated it should have been identified as a medication irregularity and, It got missed. The PC then reviewed Resident 39's penicillin and stated she completed the resident's MRR on 6/23/25. The PC reviewed Resident 39's antibiotic without a stop date and it was not identified on the June MRR. The PC stated she had identified Resident 39's penicillin with no stop date for April and May 2025 and she wrote a letter to the physician recommending it to have a stop date. The PC was informed Resident 39 was not a resident at the facility in April and May 2025 and was admitted on [DATE]. On 7/24/25 at 4:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 33 and Residents 39's antibiotics should have had a stop date and prolonged duration of antibiotics could cause resistance and other health effects. The DON acknowledged the residents' antibiotics without stop dates should have been identified as irregularities during the June 2025 MRR. A review of the facility's policy titled XVII Pharmacy Medication Regimen Review, revised 11/2017, indicated, A. The consultant pharmacist performs the review of each resident's medication regimen monthly, which shall include but are not limited to all psychotropic and antibiotic medication orders (active and discontinued) used since previous review.Based on information gathered during medication monitoring, the pharmacist evaluates (but not limited to): 1. The continued appropriateness of the medication and dosage.4. Inappropriate doses ordered or administered.6. The need to discontinue any medication à unnecessary meds. A review of the facility's policy titled Antibiotic Stewardship - Staff and Clinician Training and Roles, revised 2016, indicated, .Consultant Pharmacist: 1. During the drug regimen review, the consultant pharmacist will identify, and flag, orders for antibiotics that are not consistent with antibiotic stewardship practices. A review of the facility's policy titled Infection Prevention and Control Policy for Antibiotic Stewardship Program, reviewed 8/29/22, indicated, The World Health Organization has reported that antibiotic resistance is one of the major threats to human health.5. Tracking.c. Pharmacy consultant will review and report antibiotic usage data including numbers of antibiotics prescribed (e.g., days of therapy) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of 15 sampled residents (Resident 33 and 39) were free from unnecessary medications when both residents were given antibiotics without verification of a stop date. As a result, there was the potential for Resident 33 and 39 to experience antibiotic resistance (when bacteria or other microorganisms evolve to become resistant to the drugs designed to kill them). Findings: 1.A review of Resident 33's Resident Face Sheet indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of Unspecified dementia (a disease affecting cognition and memory), severe, with agitation. A review of Resident 33's physician orders, dated 6/13/25, indicated an order for nitrofurantoin macrocrystal (antibiotic) 100 milligrams (mg) one capsule once a day for UTI (Urinary Tract Infection) Prophylaxis with no stop date. A review of Resident 33's medication administration record (MAR) from 6/14/25 through 7/23/25, indicated the resident received nitrofurantoin daily. 2. A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses to include urinary tract infection (UTI). A review of Resident 39's History and Physical dated 6/6/25, indicated the resident was in the hospital from [DATE] through 6/3/25, and .For presumed urinary tract infection, the patient was treated with Rocephin [antibiotic].The patient's Rocephin was completed after a 5-day course on 6/1/25 and the patient was restarted on penicillin [antibiotic]. It was suspected that the patient had osteomyelitis [bone infection] of the left second toe. The patient's urine culture on May 27, 2025 showed over 100,000 colony- forming units of Klebsiella pneumoniae [type of bacteria] which was resistant to ampicillin, cefazolin, and cefuroxime [types of antibiotics] but susceptible to Rocephin, ceftazidime, Augmentin, ciprofloxacin and Bactrim [types of antibiotics]. The patient is currently asymptomatic. A review of Resident 39's physician order dated 6/3/25, indicated the resident was to receive penicillin tablet 500 milligrams twice a day, .No end date at this time.Dx [diagnosis] urinary tract infection, site not specified. A review of Resident 39's MAR for June and July 2025 indicated the resident received the penicillin as ordered. A review of Resident 39's written care plan for Infections dated 6/5/25, indicated, Resident has prophylactic antibiotics related to chronic UTI * and osteomyelitis left second toe * Penicillin. Long term goal.Urinary tract infection will resolve On 7/24/25 at 8:30 A.M., an interview was conducted with license nurse (LN) 35. LN 35 stated Resident 39 was taking penicillin for a UTI, toe infection, and pneumonia. LN 35 reviewed Resident 39's physician order for penicillin and stated it was to treat a UTI. LN 35 stated Resident 39 did not have any signs and symptoms of a UTI while he resided at the facility. LN 35 stated there should have been a urinalysis done since he was admitted to determine if the resident had an active UTI and (continued on next page)

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to continue taking the penicillin. On 7/24/25 at 8:40 A.M., an interview and record review was conducted with LN 36. LN 36 reviewed Resident 39's clinical record and stated there was no documentation the resident had a UTI or sign and symptoms of a UTI while in the facility. LN 36 stated there were no labs done while the resident was in the facility to determine if the resident had a UTI. LN 36 reviewed Resident 39's History and Physical dated 6/6/25 and stated it was unclear why the resident was taking penicillin. LN 36 stated Resident 39's order for penicillin did not have a clear reason for there to be no stop date. LN 36 stated the penicillin order did not indicate it was prophylaxis or to treat the resident's toe. LN 36 stated the order should have been clarified with the physician to determine if a stop date for the penicillin was appropriate. LN 36 stated antibiotics given indefinitely without a stop date could contribute to antibiotic resistance and could be considered unnecessary medications. On 7/24/25 at 2 P.M., an interview and record review was conducted with the infection preventionist (IP). The IP reviewed Resident 39's physician order for penicillin and stated it needed a stop date. The IP stated, I need to call the MD [medical doctor]. We need to take him off [the penicillin] since there's no signs and symptoms of UTI. The IP stated penicillin was not appropriate for prophylaxis as it could lead to antibiotic resistance. The IP then reviewed Resident 33's clinical record and stated the resident's nitrofurantoin did not have a stop date and the indication for use was UTI prophylaxis. The IP stated Resident 33's nitrofurantoin should have had a stop date. The IP further stated antibiotics without a stop date could be unnecessary medication and contribute to the development of antibiotic-resistant organisms. On 7/24/25 at 2:24 P.M., a telephone interview was conducted with the facility's pharmacist consultant (PC). The PC stated for residents to continue taking antibiotics without a stop date, there should be a valid reason from the MD documented in the residents' clinical record. The PC stated antibiotics given without a stop date could be unnecessary medications and lead to antibiotic resistance. On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated physician orders for antibiotics should be reviewed for a stop date and clarified with the MD with a valid reason documented in the clinical record to continue taking them indefinitely. The DON stated Resident 33 and Resident 39's antibiotics without a stop date should have been identified. The DON stated antibiotics given without a stop date may lead to antibiotic resistance. According to the World Health Organization's online article titled Antimicrobial Resistance Hypervirulent Klebsiella pneumoniae- Global Situation, dated 7/31/24, .Klebsiella pneumoniae (K. pneumoniae) is a Gram-negative, bacteria.[it] is a leading cause of infections acquired in health-care institutions globally and has been considered an opportunistic pathogen.Two main types of antibiotic resistance have been commonly identified: one mechanism involves the expression of enzymes known as extended spectrum β-lactamases (ESBL), which render bacteria resistant to the following antibiotic groups: penicillins. A review of the facility's policy titled XVII Pharmacy Medication Regimen Review, revised 11/2017, indicated, .Based on information gathered during medication monitoring . 1. The continued appropriateness of the medication and dosage.4. Inappropriate doses ordered or administered.6. The (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need to discontinue any medication à unnecessary meds. A review of the facility's policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated, .2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics .4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include:.i. Stop date; j. Total days of therapy.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure food and nutrition services staff was able to safely and effectively carry out the functions of the department, when one Dietary Aide (DA 22) incorrectly demonstrated how to calibrate a food thermometer. This failure in staff competence could led to incorrect food temperature, which could increase the risk of foodborne illness in the resident population of 47. Findings: On 7/23/25 at 11:22 A.M., an observation of DA 22 calibrating the food thermometer, with the presence of the Registered Dietitian (RD) and an interview was conducted with DA 22. DA 22 put some ice into a glass then put some water into it. DA 22 immersed the food thermometer into the glass with the probe touching the bottom and side of the glass. DA 22 stated he was unable to get the right temperature to calibrate the food thermometer. DA 22 asked Do I have to put more ice in it? On 7/24/25, a review of DA 22's culinary competency assessment tool was conducted. The assessment tool indicated DA 22 was signed off as competent on calibrating a food thermometer on 1/19/24. On 7/24/25 at 4:43 P.M., an interview was conducted with the Executive Officer (EO), the RD and the Director of Culinary (DOC). The RD stated the competency of the dietary staff was a facility's project for the last six months and the expectation was for the dietary staff to be receiving their competency and be followed annually. A review of the facility's policy, titled Resource: Taking Accurate Temperature, dated 7/22, indicated, .Start with an accurately calibrated thermometer.Ice Point Method.2. Place the thermometer probe into the ice water mixture. It is important to wait about 30 seconds without having the probe touch the sides or bottom of the container.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary measures were met in the kitchen during dietary operations according to standards of practice when: 1.Food item had brown spots and was not able to be served to the residents. 2. Cool down process (hot food must be cooled within 2 hours to 70 degree Fahrenheit, additional 4 hours to less than 41 degree Fahrenheit, total of 6 hours to cool down hot foods) was not properly followed per the facility's policy on handling potentially hazardous food (PHF, means any food which consists in whole or in part of milk or milk products, eggs, meat, poultry, rice ,fish, shellfish, edible crustacean, raw-seed sprouts, heat-treated vegetables and vegetable products and other ingredients in a form capable of supporting rapid and progressive growth of microorganism) item. These findings had the potential to expose the facility's residents to unsafe and unsanitary food practices that could lead to widespread foodborne illnesses.Findings: 1. On 7/21/25 at 8:07 A.M., an observation of the produce walk-in refrigerator and an interview was conducted with the Dietary Aide (DA) 23. There were three pieces of green bell pepper with white porous materials and a jalapeno pepper with three brown dots in it. DA 23 stated, They will be discarded. On 7/23/25 at 11:15 A.M., an interview was conducted with the Registered Dietitian. The RD stated she was informed of the green peppers with molds in it. The RD stated the kitchen staff were supposed to inspect the food items/ produce. The RD stated The cook will see it and they will not serve it. It is important for food safety and quality. A review of the facility's policy titled, General Food Preparation and Handling, dated 7/22, indicated, Food items will be prepared to conserve maximum nutritive value, develop, and enhance flavor and keep free of harmful organisms and substances.2. Food Storage, a. Food will be received, checked and stored properly. 2. On 7/23/25 at 3:20 P.M., a review of the kitchen's cool down process log was reviewed with the Registered Dietitian (RD) and the Director of Culinary (DoC). The cool down log indicated the cooked chicken was placed in the chiller on 7/23/25 at 10 A.M. at 175-degree Fahrenheit. There was no temperature checked of the cooked chicken after 2 hours (12 noon). The RD stated, There should be a temperature check after 2 hours. It was important for the kitchen staff to check the food and ensure the cool down process was followed to prevent food borne illness, the food might be in the danger zone. The RD stated the DA who prepared the cool down process was gone for the day. A review of the facility's policy, titled Use of Leftover, dated 7/22, indicated, .Leftovers will be properly handled and used or discarded as appropriate.3. Leftovers must be cooled to 70 degrees Fahrenheit within 2 hours and then to 41-degree Fahrenheit withing another 4 hours.

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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 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** Based on interview, observation, and record review, the facility failed to implement their infection control policies and procedures when:1. Hand hygiene (washing hands or using hand sanitizer) was not offered to residents prior to eating in the dining room.2. Hand hygiene was not consistently performed during wound treatment. As a result there was a potential for cross contamination and transmission of infections to residents, staff, and visitors. 1a. On 7/21/25 at 11:20 A.M., an observation was conducted in the dining room. Two female residents in wheel chairs were being assisted by staff to table 10. Staff did not offer hand wipes or sanitizer to both residents. On 7/21/25 at 11:40 A.M., an observation of the female residents at table 10 was conducted. One of the two female residents was wheeled out of the dining room; Resident 42 remained seated and ate her lunch. Resident 42 held the bread roll with bare hands. On 7/21/25 at 12:40 P.M., an interview was conducted with Resident 42 from table 10. Resident 42 stated the staff did not offer hand wipes or hand sanitizers to clean their hands prior to meals. On 7/21/25 at 12:48 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated she was not at the dining room when Resident 42 was seated in table 10. CNA 5 stated whoever brought the resident to the dining room should offer hand wipes to the residents. CNA 5 stated the staff should offer hand wipes before and after for their meals for hygiene and infection control. On 7/24/25 at 2:29 P.M., an interview was conducted with the Infection Preventionist (IP), The IP stated the staff should have provided the residents with wipes or offered to wash their hands. The IP stated the residents should have clean hands before eating. The IP stated a lot of residents were dependent. The IP stated it was important to maintain hand hygiene for the residents and keeping their fingers clean to prevent an infection. On 7/24/25 at 3:36 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the staff should offer hand sanitizer, encourage residents to perform hand hygiene for infection control. 1 b. On 7/21/25 at 11:50 A.M., a dining observation was conducted in the Garden Dining Room. There were 14 residents observed sitting at tables and eating lunch. Three staff members were present in the dining room. Resident 30 was seated at the table eating lunch, and he stated he was not offered hand hygiene and did not perform hand hygiene prior to his lunch tray being served. Resident 28 was wheeled to a table by a certified nursing assistant (CNA) 5. Resident 28 was not offered hand hygiene by the staff and did not perform hand hygiene prior to her lunch tray being served. On 7/21/25 at 12:05 P.M., an interview was conducted with CNA 5. CNA 5 stated she did not offer hand hygiene to Resident 28. CNA 5 stated it was important to perform hand hygiene prior to eating to clean hands to prevent infection. On 7/23/25 at 8:42 A.M., a dining observation was conducted in the Garden Dining Room. Two staff members were present. Resident 30 was seated at a table eating breakfast and he stated he was not offered hand hygiene and did not do hand hygiene prior to being served his breakfast tray. Resident 28 was seated at table eating breakfast. Resident 28 stated she was not offered hand hygiene prior to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being served her breakfast tray. Resident 27 was seated at a table eating breakfast. Resident 27 stated she was not offered hand hygiene and did not perform hand hygiene prior to being served her breakfast tray. Resident 27 stated she did not need to do hand hygiene because, I took a shower earlier this morning. On 7/24/25 at 2:30 P.M., an interview was conducted with the Infection Preventionist (IP). The IP stated that residents should perform hand hygiene prior to eating in the dining room. The IP stated he put the hand disposal wipes on each table so that staff would remember to do hand hygiene with the residents. The IP stated his expectation was that hand hygiene should be provided by all staff to residents – either soap and water or hand hygiene wipes prior to eating. The IP stated hand hygiene was important because prior to eating because a resident could get sick and get other residents sick. A review of the facility's policy titled, Handwashing/ Hand Hygiene, revised 10/23, indicated, The facility considers hand hygiene the primary means to prevent the spread of infections.5. Resident, family member and or visitors will be encouraged to practice hand hygiene. 2. Resident 30 was readmitted to the facility on [DATE] with diagnoses which included infection of left knee prosthesis (an artificial body part that replaces a part that's missing or no longer functional) per the facility's Resident Face Sheet. On 7/21/25, a review of the facility's roster matrix (used to identify pertinent care categories) indicated Resident 30 had a pressure ulcer/injury stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound). On 7/22/25 at 3:47 P.M., an interview was conducted with CNA 22. CNA 22 stated Resident 30 had an open wound in his left buttock and a rash between his legs. On 7/24/25 at 7:57 A.M., a concurrent interview and an observation of the Wound Nurse (WN) performing wound treatment to Resident 30 was conducted. The WN stated Resident 30 developed a pressure injury in his left buttock. The WN put a gown onto himself and a pair of gloves and with a gloved hand, he closed the door behind him touching the door knob, pulled the privacy curtain, took the remote control to put the resident's bed up, went to the left side of the bed instructing Resident 30 to turn to the right side. Then WN with the same gloves, folded Resident 30's incontinence brief, removed the old dressings from Resident 30's left buttock, put normal saline on the dry gauze, patted the gauze to Resident 30's wound then patted the wound with dry gauze. Next, WN then applied the cream to Resident 30's wounds, cleaned the sides of the wound and applied dressings. The WN performed all the tasks without changing gloves and did not perform hand hygiene in between the tasks. On 7/24/25 at 8:07 A.M., an interview was conducted with the WN. The WN stated he did not change his gloves. The WN stated he should have changed his gloves because the old dressing was considered not clean and could contaminate the wound which could cause Resident 30's wound to become infected. On 7/24/25 at 3:36 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the wound nurse to take off the gloves, and perform hand hygiene after removing the soiled dressing. The DON stated it was important to prevent contamination and prevent infection to Resident 30. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Dressings, Dry/ Clean, revised 9/13, indicated, The purpose of this procedure is to provide guidelines for the application of dry, clean dressings.Steps in Procedure.6. Put on clean gloves. Loosen tape and remove soiled dressing, 7. Pull glove over dressing and discard into plastic or biohazard bag, 8. Wash and dry your hands thoroughly.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program when two sampled residents' (Resident 33 and 39) infections and antibiotic use was not monitored and reviewed June and July 2025.As a result, Resident 33 and 39 were both on antibiotics without verification of a stop date. This potentially excessive use of antibiotics had the potential to contribute to antibiotic resistance (when bacteria or other microorganisms evolve to become resistant to the drugs designed to kill them) in the facility. Findings: 1.A review of Resident 33's Resident Face Sheet indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of Unspecified dementia (a disease affecting cognition and memory), severe, with agitation. A review of Resident 33's physician orders, dated 6/13/25, indicated an order for nitrofurantoin macrocrystal (antibiotic) 100 milligrams (mg) one capsule once a day for UTI (Urinary Tract Infection) Prophylaxis with no stop date. 2. A review of Resident 39's Resident Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses to include urinary tract infection (UTI). A review of Resident 39's History and Physical dated 6/6/25, indicated the resident was in the hospital from [DATE] through 6/3/25, and .For presumed urinary tract infection, the patient was treated with Rocephin [antibiotic].The patient's Rocephin was completed after a 5-day course on 6/1/25 and the patient was restarted on penicillin [antibiotic]. It was suspected that the patient had osteomyelitis [bone infection] of the left second toe. The patient's urine culture on May 27, 2025 showed over 100,000 colony- forming units of Klebsiella pneumoniae [type of bacteria] which was resistant to ampicillin, cefazolin, and cefuroxime [types of antibiotics] but susceptible to Rocephin, ceftazidime, Augmentin, ciprofloxacin and Bactrim [types of antibiotics]. The patient is currently asymptomatic. A review of Resident 39's physician order dated 6/3/25, indicated the resident was to receive penicillin tablet 500 milligrams twice a day, .No end date at this time.Dx [diagnosis] urinary tract infection, site not specified. A review of Resident 39's written care plan for Infections dated 6/5/25, indicated, Resident has prophylactic antibiotics related to chronic UTI * and osteomyelitis left second toe * Penicillin. Long term goal.Urinary tract infection will resolve On 7/24/25 at 8:30 A.M., an interview was conducted with license nurse (LN) 35. LN 35 stated Resident 39 was taking penicillin for a UTI, toe infection, and pneumonia. LN 35 reviewed Resident 39's physician order for penicillin and stated it was to treat a UTI. LN 35 stated Resident 39 did not have any signs and symptoms of a UTI while he resided at the facility. LN 35 stated there should have been a urinalysis done since he was admitted to determine if the resident had an active UTI and needed to continue taking the penicillin. On 7/24/25 at 8:40 A.M., an interview and record review was conducted with LN 36. LN 36 reviewed Resident 39's clinical record and stated there was no documentation the resident had a UTI or sign and symptoms of a UTI while in the facility. LN 36 stated there were no labs done while the resident (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in the facility to determine if the resident had a UTI. LN 36 reviewed Resident 39's History and Physical dated 6/6/25 and stated it was unclear why the resident was taking penicillin. LN 36 stated Resident 39's order for penicillin did not have a clear reason for there to be no stop date. LN 36 stated the penicillin order did not indicate it was prophylaxis or to treat the resident's toe. LN 36 stated the order should have been clarified with the physician to determine if a stop date for the penicillin was appropriate. LN 36 stated antibiotics given indefinitely without a stop date could contribute to antibiotic resistance. On 7/24/25 at 2 P.M., an interview and record review was conducted with the infection preventionist (IP). The IP reviewed Resident 39's physician order for penicillin and stated it needed a stop date. The IP stated, I need to call the MD [medical doctor]. We need to take him off [the penicillin] since there's no signs and symptoms of UTI. The IP stated penicillin was not appropriate for prophylaxis as it could lead to antibiotic resistance. The IP then reviewed Resident 33's clinical record and stated the resident's nitrofurantoin did not have a stop date and the indication for use was UTI prophylaxis. The IP stated Resident 33's nitrofurantoin should have had a stop date. The IP further stated he was unable to perform the oversight of the antibiotic stewardship program in June 2025 to current (7/24/25) as he was dealing with an outbreak in another area of the building (not the skilled nursing facility). The IP stated the antibiotic stewardship should have taken place and the resident's antibiotic without a stop date should have been identified and clarified with the physician. The IP stated not conducting the antibiotic stewardship program could lead to the development of antibiotic-resistant organisms. On 7/24/25 at 2:24 P.M., a telephone interview was conducted with the facility's pharmacist consultant (PC). The PC stated for residents to continue taking antibiotics without a stop date, there should be a valid reason from the MD documented in the residents' clinical record. The PC stated antibiotics given without a stop date could lead to antibiotic resistance. On 7/24/25 at 3:35 P.M., an interview was conducted with the director of nursing (DON). The DON stated physician orders for antibiotics should be reviewed for a stop date and clarified with the MD with a valid reason documented in the clinical record to continue taking them indefinitely. The DON stated Resident 33 and Resident 39's antibiotics without a stop date should have been identified by the antibiotic stewardship program. The DON stated the antibiotic stewardship program should have been ongoing no matter what was going on in other parts of the building. The DON stated antibiotics given without a stop date may lead to antibiotic resistance. According to the World Health Organization's online article titled Antimicrobial Resistance Hypervirulent Klebsiella pneumoniae- Global Situation, dated 7/31/24, .Klebsiella pneumoniae (K. pneumoniae) is a Gram-negative, bacteria.[it] is a leading cause of infections acquired in health-care institutions globally and has been considered an opportunistic pathogen.Two main types of antibiotic resistance have been commonly identified: one mechanism involves the expression of enzymes known as extended spectrum β-lactamases (ESBL), which render bacteria resistant to the following antibiotic groups: penicillins. A review of the facility's policy titled Antibiotic Stewardship - Staff and Clinician Training and Roles, revised December 2016, indicated, .Director of Nursing (DON) and Infection Preventionist (IP): 1. Administrative and management personnel with clinical oversight responsibilities will receive initial (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orientation and ongoing training on: a. The facility's antibiotic stewardship program; b. the rationale for judicious use of antibiotics.2. The DON will monitor individual resident antibiotic regimens, including:.b. compliance with start/stop dates and/or days of therapy. A review of the facility's policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated, .2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics .4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include:.i. Stop date; j. Total days of therapy. A review of the facility's policy titled Infection Prevention and Control Policy for Antibiotic Stewardship Program, reviewed 8/29/22, indicated, The World Health Organization has reported that antibiotic resistance is one of the major threats to human health.2. Accountability: a. An ASP team will be established to be accountable for stewardship activities. The ASP team may consist of:.Director of Nursing, Infection Preventionist (IP).As a team, they will: i. Review infections and monitor antibiotic usage patterns on a regular basis.iv. Report on number of antibiotics prescribed (e.g., days of therapy).