STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555545	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cove at LA Jolla	7160 Fay Avenue LA Jolla, CA 92037

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner for six of 56 residents (Residents 10, 4, 24,15,19,7) reviewed for call lights response. This failure had the potential for resident needs to go unmet and at risk for safety. Findings. On 6/3/24 a review of the past three Resident Council (when residents meet once a month to discuss facility concerns) meeting minutes was reviewed. Resident Council minutes dated 3/5/24, 4/2/24, and 5/14/24 indicated slow call light responses. The ADM response to the concerns was documented as, Noted. 1. A review of Resident 10's Admission Record indicated, Resident 10 was admitted to the facility on [DATE] with diagnoses that included acute (sudden) cystitis (an infection of the bladder). An interview on 6/3/24 at 10:30 A.M., with Resident 10 was conducted. Resident 10 stated he knew the facility was understaffed, due to call lights not being answered timely and it would take more than 20 minutes or more to get a response. During State run Resident Council meeting on 6/4/24 at 10 A.M., Resident 10 stated call light responses were worse after meals when staff were on break. Resident 10 stated he was incontinent (no control) of both bowel and bladder and had to wait for twenty minutes or more for staff to changed him. Resident 10 stated night shift was worst because they had less staff working. A record review of Resident 10's Minimum Data Set (MDS- a clinical assessment tool), dated 3/18/24, indicated Resident 10 had a Brief Interview for Mental Status (BIMS-a cognitive score) score of 14, which indicated cognition was intact. 2. Resident 4 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (when the heart pumps ineffectively), per the Admission Record. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/3/24 at 11:00 A.M., with Resident 4 was conducted. Resident 4 stated, response to call lights was dependent on the time of day, which was usually on nights and weekends. Resident 4 stated the CNAs answered call lights in 15 or 20 minutes. Resident 4 stated she required assistance in going to bed and used of the bathroom before bedtime and in the middle of the night. A record review on 6/5/24 of Resident 4's MDS dated [DATE], listed a BIMS score of 13, indicating cognition was intact. 3. Resident 24 was admitted to the facility on [DATE], with diagnoses which included cellulitis of right lower limb (infection of the soft tissue in the leg), per the facility's Admission Record. An interview on 6/3/24 at 11:15 A.M., with Resident 24 was conducted. Resident 24 stated the facility was short of staff on weekends and it took time for the call lights to get answered. A record review on 6/5/24 of Resident 24's MDS listed a BIMS score, dated 4/10/2024 of 15, indicating cognition was intact. 3. Resident 15 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease, (ineffective gas exchange in the lungs), per the facility's Admission Record. An interview on 6/3/24 at 3:07 P.M., with Resident 15 was conducted. Resident 15 stated he does not have any issues or concerns with the facility, except the call lights. Resident 15 stated the call lights was worst at nighttime, and it took a while for staff to respond which was around 30 minutes or even more. A record review on 6/5/24 of Resident 15's MDS dated [DATE], listed Resident 15's BIMS score was 15, indicating cognition was intact. 4. Resident 19 was admitted to the facility on [DATE], with diagnoses which included acute (sudden) respiratory failure, per the facility's Admission Record. An interview on 6/4/24 at 11:30 A.M., with Resident 19 was conducted. Resident 19 stated he had a stroke three times and was on a heart monitor. Resident 19 stated he needed bathroom assistance at times, so he would use his call light. Resident 19 stated it would take a while for his call light to get answered. Resident 19 stated the facility was short of help on the evenings, night shifts, and on the weekends. A record review on 6/5/24 of Resident 19's MDS listed a BIMS score was 14, indicating cognition was intact. 5. Resident 7 was admitted on [DATE], with diagnoses which included hemiplegia (stroke, weakness on one side of the body) affecting the right dominant side, per the facility's Admission Record. An interview on 6/5/24 at 12:08 P.M., with Resident 7 was conducted. Resident 7 stated when he used the call light, sometimes it took 30 minutes for staff to respond. Resident 7 stated, the staff were busy, and he thought less people were working, especially in the evening and at night. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review on 6/5/24 of Resident 7's MDS dated [DATE], listed a BIMS score of 9, indicating cognition was moderately impaired. An interview on 6/5/24 at 3:36 P.M., with CNA 1 was conducted. CNA 1 stated residents call lights needed to be answered as soon as possible to meet residents needs and ensure residents safety. CNA 1 stated call lights should be answered in less than five minutes and not any longer. An interview on 6/5/24 3:48 P.M., with CNA 2 was conducted. CNA 2 stated, call lights needed to be answered within five to ten minutes to meet resident needs and to ensure residents were safe. An interview on 6/5/24 at 3:50 P.M., with CNA 3 was conducted. CNA 3 stated call lights should be answered in five minutes, not ten minutes. CNA 3 stated they should answer to call lights promptly to ensure resident needs were met and ensure their safety. An interview on 6/5/24 at 4 P.M., with LN 1 was conducted. LN 1 stated call lights were important to be answered promptly within at least five minutes to meet residents needs and ensure resident safety. An interview on 6/5/24 at 4:16 P.M., with the DON was conducted. DON stated call lights were important to get answered in a timely manner, at least within five minutes, to make sure the resident needs are met promptly and ensure safety. A review of the facility's Policy & Procedure - entitled Nursing Clinical Subject: Call light / Bell undated, . Procedures: 1. Answer the light/ bell within a reasonable time .3. Listen to the resident's request /need .

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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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to accurately assess and code the Minimum Data Set (MDS-a clinical assessment tool) for three of four residents (1, 5, 103) reviewed for wander guards (a wrist band worn by residents that alarms and alerts staff when the resident get near or exit a specific area). As a result, the Centers for Medicare and Medicaid Services (CMS) was unaware of Resident 1, 5, and 103's current health status and wandering behavior. Findings: a. Resident 1 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (a disease of the brain which affects daily function), per the facility's Admission Record. On 6/5/24, Resident 1's clinical record was reviewed: According to the physician's order, dated 2/21/24, .WanderGuard wrist band to LEFT Wrist . According to the quarterly Elopement/Wandering Evaluation, dated 4/2/24, Resident 1 was categorized as a high risk for elopement. The care plan titled At Risk for Elopement, undated, listed interventions such as: Monitor Wander guard placement (left wrist). According to the nurses' notes, dated 10/8/23 at 3:16 P.M., the family approved of the use of a wander guard. The quarterly MDS, dated [DATE], Section P-Restraints and Alarms was coded 0, indicating a Wander/elopement alarm was not in use. b. Resident 5 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 6/5/24, Resident 5's clinical record was reviewed: According to the physician's order, dated 9/15/23, .WanderGuard wrist band to LEFT Wrist . According to the quarterly Elopement/Wandering Evaluation, dated 5/2/24, Resident 5 was categorized as a high risk for elopement. The care plan titled At Risk for Elopement/wandering related to Dementia, dated 7/8/23, listed interventions such as: Monitor Wander guard placement (left wrist). According to the nurses' notes, dated 7/8/23 at 9:18 P.M., the family approved of the wander guard placement. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS, dated [DATE], Section P-Restraints and Alarms was coded 0, indicating a Wander/elopement alarm was not in use. c. Resident 103 was admitted to facility on 5/15/24, with diagnoses which included encephalopathy (a disease of the brain which affects daily function), per the facility's Admission Record. According to the physician's order, dated 5/17/24, .WanderGuard wrist band to (L. Wrist) . According to the admission Elopement/Wandering Evaluation, dated 5/17/24, Resident 103 was categorized as a high risk for elopement. The care plan, titled Wander guard to L. wrist related to intermittent confusion, undated, listed interventions such as: Monitor Wander guard placement (left wrist). According to the nurses' notes, dated 5/17/24 at 10:56 A.M., Resident and emergency contact agree with wanderguard plan. The admission MDS, dated [DATE], Section P-Restraints and Alarms was coded 0, indicating a Wander/elopement alarm was not in use. On 6/5/24 at 9:36 A.M., an interview and record review was conducted with the Minimum Data Set Nurse (MDSN). The MDSN stated when preparing quarterly or annual MDS evaluations, she reviewed the physician orders, nurses' notes, and visually checked the resident. The MDSN reviewed Resident 1, physician orders and verified the wander guard orders and then checked the MDS Section P-Restraints and Alarms coding. The MDSN stated I missed it. The MDSN stated because the MDS was not coded accurately, CMS was unaware of the resident's current status. The MDSN reviewed Resident 5 and 103 physician's order and coding for MDS Section P-Restraints and Alarms coding. The MDSN stated my assistant missed Resident 5's and Resident 103's coding. The MDSN stated she would need to correct these immediately, so CMS was aware of the residents' wandering behavior. On 6/05/24 at 10:44 A.M., an interview was conducted with the DON. The DON stated elopement and wandering behavior was a safety issue and needed to be monitored. The DON stated she expected the MDS to identify the residents at risk for elopement and what efforts were put in place to prevent the risk. The DON stated she expected all residents to be assessed and coded properly, so CMS was aware of the residents' current status. According to the Resident Assessment Instrument Tool 3.0 Manual, dated October 2019, Section P: Restraints and Alarms, P0200: Alarms, . Identify all alarms that were used at any time (day or night) during the 7-day look-back period. Code the frequency of use: .Code 0, Not used .Code 2, used daily .

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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** 46980 Based on interview and record review, the facility failed to create a person centered care plan related to pain management involving non-pharmacological interventions for one of five residents (Resident 2), reviewed for pain management. This outcome had the potential for Resident 2's pain to be managed only through pharmacological interventions. Findings: Resident 2 was admitted to the facility on [DATE], with diagnoses that included displaced oblique fracture of shaft of left femur (an angled break in the long bone of the thigh) and fracture of the lower end of the left femur (a break in the long bone of the thigh near the knee), per the Admission Record. On 6/3/24 at 3:14 P.M., an interview was conducted with Resident 2 who stated her, Hip pain can get very bad. Resident 2 stated her pain was managed by the facility only with medication and repositioning. On 6/5/24 at 9:15 A.M., a record review of Resident 2's was conducted. According to the physician orders, dated 5/31/24, methadone 12.5 milligrams (a synthetic pain reliever similar to morphine) every eight hours for pain management and non-pharmacological interventions for pain 1 = repositioning, 2 = dim light/ quiet environment, 3 = relaxation 4 = distraction, 5 = music, 6 = massage. A review of care plan titled Pain, undated, listed only one intervention which was repositioning. According to the Medication administration Record (MAR) for May 2024, the MAR only listed repositioning as an attempted non-pharmacological intervention. On 6/05/24 at 9:50 A.M., an interview was conducted with Resident 2. Resident 2 stated no staff have offered any other pain management interventions other than repositioning. On 6/05/24 at 9:53 A.M. an interview and concurrent record review was conducted with the DON. The DON stated, I don't see any non-pharmacological suggestions in the care plan except repositioning. (Resident 2's) preferences for interventions are not reflected in the care plan and they should be. A review of the facility policy entitled Comprehensive Person-Centered Care Planning, undated, It is the policy of this facility that the interdisciplinary team (IDT-when department heads meet to discuss resident care) shall develop a comprehensive person-centered care plan for each resident .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46980 Based on observation, interview, and record review, the facility failed to follow professional standards for food safety when: 1. Dishware was not properly stored; and 2. Date on powdered thickener did not indicate open, discard, or preparation date; and 3. Gloves were not changed and hand hygiene was not conducted during food service. This failure had the potential to cause food-borne illness to all residents in the facility. Findings: 1. On 6/3/24 at 8:15 A.M., during an initial tour of the kitchen with the Certified Dietary Manager (CDM), an observation of [NAME] 1 (CK 1) was conducted. CK 1 was observed removing wet dishware from the dish machine and immediately stacking them on a nearby metal rack, without allowing them to air dry first. The CDM stated, Dishes shouldn't be stored wet, because there's a risk of bacterial growth that could effect everyone who eats food from our kitchen. A review of the facility policy titled Dish Washing dated 2018, .Dishes are to be air dried in racks before stacking and storing . 2. On 6/3/24 at 8:24 A.M., during an initial tour of the dry storage room with the CDM, tubs of powdered thickener were observed in two clear, plastic bins, located on a storage rack. The two clear bins were labeled on the outside with, 5/28/24. The CDM stated the thickener label did not indicate what the date referred to. The CDM stated, It's probably the received date, but no one would know. There should be three dates: received, opened, and use by. 3. On 6/04/24 at 12:12 P.M., an observation and interview was conducted with the CDM during lunch trayline. CK 1 was observed wearing gloves while plating food for lunch. CK 1 held food scoops with his gloved hand then placed his left thumb on the food surface of numerous plates. CK 1 wore the same gloves and made a sandwich, cut the sandwich and was touching other surfaces without removing his gloves, or performing hand hygiene. The CDM stated, That is a cross-contamination risk. Gloves should be changed between activities and hand hygiene performed. A review of the facility policy titled Sanitation, dated 2018 indicated, .Dishes are to be handled on the rim of plates . hands must not contact the food surface . On 6/6/24 at 11 A.M., an interview was conducted with the RD. The RD stated the dishes should always be air dried. The RD stated best practice should be to include three dates. One date was the date received, one date would be the date the product was opened, the the third date would be the date to use the item by. The RD stated touching food surfaces caused contamination.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to accurately calculate the fluid intake and urinary output (measurement of urine daily), for one of one resident (Resident 106), reviewed for accurate documentation. As a result, Resident 106's clinical record was not correct, which had the potential to affect his care for fluid balance. Findings: Resident 103 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (an infection in part of the urinary system), per the facility's Admission Record. On 6/3/24 at 9:01 A.M., an observation was conducted of Resident 103, as he laid in bed. A urinary catheter (a flexible tube inserted into the bladder, in order to drain urine to an external collection bag) bag was attached to the left lower bed frame, which was covered in a blue dignity bag (a bag that covers the urine collection bag to protect a person's dignity). The urine in the tubing was dark yellow and cloudy looking. An interview was conducted with CNA 11 on 6/5/24 at 1:13 P.M. CNA 11 stated urinary catheter bags needed to be emptied at least once a shift. CNA 11 stated if input/output measurements were ordered by the physician, the urine was measured in a cylinder measuring container, after the catheter bag was emptied. CNA 11 stated she would write down the amount of urine removed and then inform the licensed nurse, so the amount could be documented and calculated on a 24-hour basis. An interview was conducted with LN 12 on 6/5/24 at 1:17 P.M. LN 12 stated the CNAs measured the urine when removed from a urinary collection bag and reported the amount to the licensed nurses. LN 12 stated input/output orders were important for physicians and staff, to ensure adequate fluid balance were occurring and residents were not fluid overloaded or dehydrated. On 6/5/24, Resident 106's clinical record was reviewed: According to the physician's order, dated 5/29/24, .Indwelling catheter #16 F (size) .Monitor intake and output every shift .Calculate total 24 hours intake and output every evening shift . Resident 106's Medication Administration Record (MAR) was reviewed from 5/29/24 through 6/4/24. The intake (oral fluid intake) and output (catheter urine output) for the day shift (7 A.M.-3:30 P.M.), evening shift (3 P.M.-11:30 P.M.) and night shift (11 P.M.-7:30 A.M.) on 5/31/24 was documented as: Day shift: (in) 800 milliliters (ml) , (out) x 2 Evening: (in) 450 ml, (out) 350 ml (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night: (in) 200 ml, (out) 500 ml The calculated total for 24-hour input and output on 5/31/24 was documented as: Total in: 1050 ml Correct calculation for input was 1450 ml Total out: 1650 ml Correct calculation for output was 850 ml The documented input and output for 6/1/24 was documented as: Day shift: (in) 500 ml, (out) x 2 Evening : (in) 480 ml, (out) 350 ml Night: (in) 120 ml, (out) 600 ml The calculated total for 24-hour input and output on 6/1/24 was documented as: Total in: 1180 ml Correct calculation for input was 1100 ml Total out: 1200 ml Correct calculation for output was 950 ml The documented input and output for 6/2/24 was documented as: Day shift: (in) 700 ml, (out) x 2 Evening : (in) 480 ml, (out) 500 ml Night: (in) 200 ml, (out) 450 ml The calculated total for 24-hour input and output on 6/2/24 was documented as: Total in: 1300 ml Correct calculation for input was 1380 ml Total out: 2000 ml Correct calculation for output was 950 ml The documented input and output for 6/4/24 was documented as: Day shift: (in) 660 ml, (out) 400 ml Evening : (in) 240 ml, (out) 300 ml Night: (in) 240 ml, (out) 300 ml The calculated total for 24-hour input and output on 6/4/24 was documented as: Total in: 1240 ml Correct calculation for input was 1140 ml (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Total out: x 5 Correct calculation for output was 1000 ml According to the care plan, titled Indwelling Catheter, undated, listed interventions such as: Monitor and document intake and output as per facility policy. On 6/5/24 at 1:39 P.M., an interview and record review was conducted with LN 11 of Resident 106's MAR. LN 11 stated monitoring I&Os (input and output) was important for early detection of fluid imbalances or potential problems. LN 11 stated the CNAs were expected to measure the urine output from a urinary catheter and report the amount to the licensed nurse for documentation. LN 11 reviewed Resident 106's MAR, listing the output as x 2 and x 5. LN 11 stated there should not be any x 2 or x 5 listed on the output, because a measurable numerical number was expected, especially with a urinary catheter. LN 11 stated the totals for the end of the 24-hour period should be an accurately balanced, because the physicians and nurses were analyzing the data. LN 11 stated if the input and output was not accurately documented, you could not tell if the resident's fluid status was safe or not. On 6/5/24 at 10:44 A.M., an interview and record review was conducted with the DON of Resident 106's MAR. The DON stated Resident 106's MAR was inaccurate, because x 2 and x 5 were not numerical numbers. The DON stated the 24-hour totals did not match with the shift totals for input and output. The DON stated accurate documentation was required in order to provide quality of care. The DON stated the I&O numerical values did not balance out, so everyone was unaware of what Resident 106's true fluid balance was on a daily basis. According to the facility's policy titled Charting and Documentation, undated, The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's treatment .Importance and Use of the Records: .3. To the physician, it guides him in his treatment, use and effects of drugs and plan for care .

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 39220 Based on interview and record review, the facility failed to make a good faith attempt to address root cause issues brought forth by the resident council meeting in their Quality Assurance Performance Improvement (QAPI) committee meetings, related to timely call light responses. (Cross Reference F-558) This failure had the potential to affect the care provided to residents. Findings: An interview was conducted with the ADM on 6/6/24 at 10:25 A.M. The ADM stated call light responses were added to their QAPI plan in March 2024, after the March Resident Council identified the issue during their monthly meeting. The ADM stated call light responses were identified again as an issue in the April and May 2024, Resident Council meetings. The ADM stated the staff were immediately in-serviced on call light responses and call light responses were included as a question during the morning Angel Rounds (when department heads are assigned to a specific rooms, to meet with resident every morning in order to identify concerns). The ADM stated the Angel Round responses were not documented, but were verbally brought to the team every morning during their stand-up (department heads meet to discuss issues that occurred during the night or morning). The ADM stated call light response audits had previous been started in January 2024, via their computerized call light response system, which tracks the length of time a call light is on, before answered and deactivated. The ADM stated the QAPI compliance goal was divided into three sections: under 5 minute, over 5 minutes, and 30 minute responses. The ADM stated sometimes they reached the compliance goal and other times they did not. The ADM stated the staff in-services did not include leaving the call lights on, until the resident's needs were met. The ADM stated during the call light audit, she had not divided and analyzed into staff shifts (days, evenings, and night shifts) or nursing units, but bunched all the time responses together to get the current data. The ADM stated they were aware the delayed call light responses were still a problem and they were not getting to the root of the problem, based on their ongoing audits and Angel Rounds. According to the facility's policy titled Quality Assurance and Performance Improvement, dated January 2022, The facility will establish and implement a Quality Assessment and Assurance committee .and implement Performance Improvement Projects (PIPs) through a data driven and proactive approach .6.The facility may utilize the following established Performance Improvement tools/Processes: A. Plan-Do-Study-Act (PDSA cycles). B. The Five Why's to identify root cause .