STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555745	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Carlsbad	3140 El Camino Real Carlsbad, CA 92008

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent the formation of pressure injuries (wounds caused by sustained pressure to bony areas of the body) for one of three residents (Resident 1) reviewed for wounds.This failure resulted in Resident 1 sustaining pressure injuries to both heels.Findings:During a record review, Resident 1 was admitted on [DATE] with diagnoses which included a fracture of left femur (a large bone extending from the hip to the knee), and need for assistance with personal care.During a record review, Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool) dated 11/22/25 indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to measure cognitive, or thinking, skills) of 10 which indicated moderate cognitive impairment. The MDS further stated Resident 1 required substantial to maximal assistance with bed mobility and was at risk for developing pressure ulcers/injuries.A concurrent observation was conducted on 2/24/26 at 10:59 A.M. inside Resident 1's bedroom. Resident 1 was observed sitting in her wheelchair, wearing thick cushioned boots over both feet. Resident 1 stated she wore the boots because she had wounds on her feet, but was unsure how she sustained the wounds.During an interview with Licensed Nurse (LN) 1 on 2/24/26 at 11:05 A.M., LN 1 stated Resident 1 was wearing Prevalon Boots (cushioned boots designed to help reduce pressure to the heels) because she developed blisters to both heels. LN 1 stated the blisters were caused by prolonged pressure to the heels. LN 1 stated Resident 1 did not have any wounds when she was admitted . LN 1 stated Resident 1 probably sustained the pressure injuries to the heels because she refused to be turned and repositioned while in bed.During an interview with Certified Nursing Assistant (CNA) 1 on 2/25/26 at 9:40 A.M., CNA1 stated she noticed Resident 1 had black/purple blisters on her heels on 12/9/26. CNA1 stated she reported it to the treatment nurse. CNA1 stated Resident 1 developed the wounds because [Resident 1] doesn't like getting up out of bed. CNA1 stated, every time we encourage her to get up, she says ?No, I don't want to. CNA1 stated Resident 1 also refused to be repositioned on her side when in bed. CNA 1 stated having someone that constantly wants to be in bed, they're bound to have friction on the skin. CNA 1 stated Resident 1 was on a two-hour repositioning schedule along with other residents. There was no individualized repositioning schedule for Resident 1.During a telephone interview with Resident 1's Primary Care Physician (PCP), the PCP stated Resident 1 was at high risk to develop pressure injuries. The PCP stated, in his opinion Resident 1's pressure injuries were not 100% avoidable.to some extent [the pressure injuries] were unavoidable.did the facility have a duty to identify early on with off-loading? Probably.During an interview with the Director of Nursing (DON) ON 3/12/26 at 2:36 P.M., the DON stated Resident 1 was at risk to develop pressure injures. The DON stated having a fractured hip along with refusals to get out of bed/refusals to be turned and repositioned placed her at higher risk. The DON stated it was her expectation that nursing implemented a care plan to address Resident 1's refusal to get out of bed and turn, and this could have prevented the pressure injuries.During a record review of the facility's policy, the policy titled Pressure Injury Prevention, revised 4/2020 indicated, Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team .Choose a frequency for repositioning based on the resident's risk factors and current clinical guidelines.

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