STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555745	A. Building B. Wing	02/06/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to ensure a comprehensive assessment was completed accurately for one of 12 sampled residents (Resident 146) when Resident 146's Minimum Data Set (MDS, an assessment tool) did not reflect she had an indwelling catheter (a thin, flexible tube inserted and left in the bladder to collect and drain urine). This failure increased the risk for Resident 146 to not receive the appropriate care. Findings: Resident 146 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute kidney failure (when the kidney suddenly stops working correctly) and urinary tract infection (UTI- an infection in the bladder/urinary tract) per the Admission Record. An observation was conducted on 2/3/25 at 9:38 A.M. in Resident 146's room. Resident 146 was observed to have an indwelling catheter. A review of Resident 146's medical record was conducted on 2/3/25 at 11:31 A.M. Resident 146's MDS assessment, dated 1/15/25, indicated Resident 146 did not have an indwelling catheter. An interview and record review were conducted with the Director of Nursing (DON) and the Director of Staff Development (DSD) on 2/5/25 at 1:35 P.M. A review of nursing documentation, dated 1/9/25 at 12:55 A.M., indicated Resident 146 had an indwelling urinary catheter. A review of a physician's note, dated 1/13/25 at 12:54 P.M., indicated .Patient does have [an indwelling] catheter . An interview and record review were conducted with the DON on 2/5/25 at 2:56 P.M. The DON stated the MDS, dated [DATE], did not reflect Resident 146 had an indwelling catheter. The DON stated the MDS should have been accurate and reflected Resident 146 had an indwelling catheter. The DON stated the MDS assessment should have been accurate as it would have helped create Resident 146's plan of care. A review of the facility's policy titled Resident Assessments, revised October 2023, indicated .All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information . (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare & Medicaid Services' (CMS, a federal agency) Long-Term Care Facility Assessment Instrument 3.0 User's Manual (a manual on how to complete the MDS assessment tool), dated October 2024, indicated .multiple regulatory requirements .require that (1) the assessment accurately reflects the resident's status .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 98), who were unable to carry out activities of daily living (ADL-self- care activities such as grooming), received assistance with nail care (cleaning, trimming and/or filing of nails) and removal of facial hair. This failure resulted in Resident 98 having long fingernails, and facial hair which had the potential to negatively impact the resident's self-esteem and comfort. Findings: Resident 98 was admitted to the facility on [DATE], with diagnoses including sepsis (infection in the blood) and muscle weakness according to the facility's Admission Record. A review of Resident 98's history and physical, completed by Resident 98's attending physician, dated 1/28/25, indicated Resident 98 could make needs and concerns known. A review of Resident 98's minimum data set (MDS - a federally mandated resident assessment tool), dated 2/2/25, Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 7/15, (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Resident 98's functional abilities of the MDS indicated Resident 98 required maximum assistance on personal hygiene. On 2/3/25 at 12:47 P.M., an observation was conducted with Resident 98 in the dining area. Resident 98 had facial hair and long fingernails. On 2/3/25 at 2:25 P.M., an observation was conducted with Resident 98 in her room. Resident 98 still had facial hair and long fingernails. A review of Resident 98's care plan on ADLs was conducted. The care plan indicated one of Resident 98's interventions was for the staff to check Resident 98's nail length and trim and clean on bath day and as necessary. On 2/5/25 at 8:12 A.M., a follow up observation and an interview was conducted with Resident 98 in her room. Resident 98 still had facial hair and long fingernails. Resident stated her nails were long and needed to be cut. On 2/5/25 at 9:19 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated Resident 98 was under her care yesterday 2/4/25 and today, 2/5/25. CNA 11 stated she had not seen Resident 98's fingernails and did not notice Resident 98's facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:27 A.M., a joint observation of Resident 98, an interview of Resident 98 and an interview with CNA 11 was conducted. Resident 98 had facial hair and long fingernails. Resident 98 stated she wanted her facial hair removed and her fingernails cut. CNA 11 stated she needed to remove Resident 98's facial hair and cut her fingernails. CNA 11 stated it was important to provide nail care to prevent Resident 98 scratching and cutting herself. CNA 11 stated it was to maintain Resident 98's personal hygiene and for dignity. On 2/5/25 at 4:06 P.M., an interview was conducted with the Director of Nursing. The DON stated the expectation was for the staff to ensure residents facial hair was removed and residents' fingernails were trimmed and cut per the residents' preference for hygiene and dignity. A review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good .grooming and personal .hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including .support and assistance with: a. Hygiene (.grooming) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40610 Based on interview and record review, the facility staff failed to document consistently the removal of lint from the drying machine trap after drying machine used in the laundry room. This failure had the potential to cause fire in the laundry room which could affect the safety of all residents and staff in the facility. Findings: On 2/5/25 at 10:40 A.M., an observation of the laundry room was conducted. The laundry room was separated by clean and dirty area with separate doors, an entry door to the dirty area and an entry door to the clean area. There were two staff folding linens in the clean area of the laundry room. The washing machine was in use with hot water temperature noted. The drying machine was in use with hot temperature noted. On 2/5/25 at 10:42 A.M., a review of the laundry dryers cleaning log was conducted. The laundry dryers cleaning log had missed entries from November 2024 through January 2025. The log indicated the following: - November 2024 missed entries - 11/2/24, and 11/18/24. - December 2024 missed entries - 12/13/24, 12/15/24, 12/16/24, 12/18/24, 12/20/24, 12/22/24, 12/23/24, 12/25/24, 12/26/24, 12/28/24 and 12/30/24. - January 2025 missed entries - 1/5/25, 1/7/25, 1/11/25, 1/24/25 and 1/31/25. On 2/5/25 at 10:45 A.M., an interview with laundry staff (LS) 12 was conducted with the interpretation of Payroll staff (PS) 14. LS 12 stated the facility did the laundry every day and the lint was removed from the drying machine trap every two hours. LS 12 stated it was important to remove the lint in the drying machine to ensure the dryer was cleaned for infection and the heat in the drying machine was appropriate to dry the clothes and linens. On 2/5/25 at 4:06 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the laundry staff to have removed the lint and documented in the log to show that the removal of the lint from the drying machine was done for the dryer to work effectively and to ensure prevention of fire. A review of the facility's policy titled, Fire Safety and Prevention, revised May 2011, indicated, All personnel must learn methods of fire prevention .Overheating .b. Keep filters on .dryers, etc. free of lint .

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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** 50175 Based on interview and record review, the facility failed to ensure one of three residents (Resident 146) screened for an indwelling catheter (a thin, flexible tube inserted and left in the bladder to collect and drain urine) had a physician's order for an indwelling catheter, and catheter care was consistently provided. This failure had a potential for Resident 146 to develop a urinary tract infection (UTI- an infection in the bladder/urinary tract). Findings: Resident 146 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute kidney failure (when the kidney suddenly stops working correctly) and urinary tract infection (UTI- an infection in the bladder/urinary tract) per the Admission Record. A review of Resident 146's medical record was conducted on 2/3/25. A review of active and discontinued orders for an indwelling catheter was conducted. There was an order to document output from an indwelling catheter, but there were no orders found for an indwelling catheter or indwelling catheter care from 1/8/25 through 1/25/25 A review of Resident 146's medical record was conducted with the Director of Nursing (DON) and the Director of Staff Development (DSD) on 2/5/25 at 1:35 P.M. The DON stated there was no order for an indwelling catheter or indwelling catheter care from 1/8/25 through 1/25/25. A review of nursing documentation, dated 1/9/25 at 12:55 A.M., indicated Resident 146 had an indwelling urinary catheter. A review of a physician's note, dated 1/13/25 at 12:54 P.M., indicated .Patient does have [an indwelling] catheter . The DON further stated toileting hygiene or catheter care should be performed every shift (three times a day). A review of the documentation for toileting hygiene for 1/17/25, 1/22/25, and 1/24/25 indicated toileting hygiene was not performed on all three shifts. The DON stated there were no documentation specific for catheter care found for 1/8/25 through 1/25/25. A review of a physician's progress note, dated 1/25/25 at 12:33 P.M., indicated .UTI noted . A review of the facility's policy titled Catheter Care, Urinary, revised September 2014, indicated .Purpose: the purpose of this procedure is to prevent catheter-associated urinary tract infections .The following should be recorded in the resident's medical record: 1. The date and time that catheter care was given .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50175 Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner. This failure had the potential for residents' needs to be unmet. Findings: An interview with Resident 147 on 2/3/25 at 9:18 A.M. Resident 147 stated her only concern about the facility was the call light response time. Resident 147 stated it took over half an hour to get help when needed. Resident 147 stated she needed help to be cleaned after having an incontinence episode. An interview with Resident 148 was conducted on 2/4/25 at 8:58 A.M. Resident 148 stated it took over an hour to get assistance to get ready for bed at night. An interview with Confidential Resident (CR) 1 and CR 2 was conducted on 2/4/25 at 9:57 A.M. CR 1 and CR 2 stated it took half an hour to get assistance. CR 2 stated she checked her watch and monitored the response time. CR 2 stated she needed assistance to complete various tasks. A review of the Payroll-based Journal (PBJ) Staffing Data Report (a system used by a federal agency to collect a facility's staffing information) indicated the facility had a one-star staffing quality rating for the fourth quarter of 2024 (July 2024 through September 2024). An interview was conducted with the Director of Nursing (DON) on 2/6/25 at 3:05 P.M. The DON stated it was her expectation for call lights to be acknowledged within five to 7 minutes. The DON stated it was important to answer call lights timely to meet the needs of the residents. A review of the facility's policy titled Answering the Call Light, revised September 2022, indicated .The purpose of this procedure is to ensure timely responses to the resident's requests and needs .