STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555746	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Torrey Pines Post-Acute	13101 Hartfield Ave San Diego, CA 92130

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 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** 48263 Based on observation, interview, and record review, the facility failed to initiate a baseline care plan for two of 43 sampled residents (Resident 1 and Resident 3) with actual pressure ulcers. This deficient practice had the potential to delay the necessary person-centered care needed to prevent negative outcomes. Cross reference F686 Findings: 1. A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral infarction (a stroke that occurs when blood flow to the brain is blocked). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 1/14/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 2/7/25 at 1:52 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 1 ' s admission skin assessment on 2/1/25 indicated there was an open area to coccyx [tailbone] measures 1.5x1. 5. LN 1 stated that admission nurses do not stage pressure ulcers and wait until the wound Medical Doctor (MD) stages for them but are not always available during admissions to stage pressure ulcers. LN 1 stated Resident 1 ' s pressure ulcer risk assessment indicated a score of 17 (0-18) that indicated moderate risk (below 9 indicated high risk). LN 1 stated there was no actual pressure ulcer care plan until 2/4/25 (three days after admission) that was initiated by the wound RN. LN 1 stated this should have been included in Resident 1 ' s 48-hour baseline care plan if Resident 1 did have an actual pressure ulcer to prevent any worsening or delay in pressure ulcer care. A clinical chart review for Resident 1 was conducted, which indicated: - The admission assessment titled, Skilled Nursing Initial Eval was conducted by a Registered Nurse [RN] on 2/1/25. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Bayshire Torrey Pines Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13101 Hartfield Ave San Diego, CA 92130	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Admission ordered on 2/1/25 indicated, .Treatment: Sacralcoccyxgeal [tailbone and the triangular shaped bone to the lower spine] open wound. Apply Barrier Cream To Area To Protect Skin For Maint [maintenance] Tx [treatment] x14 Days BID [twice daily] &PRN [as needed] every day and evening shift for (Skin Integrity Prevention) for 14 Days . - Skin & Wound Evaluation: 2/4/25 In-house Stage III Sacrum Present on admission. Measurements area: 0. 6cm length 1.2 cm width 0.6 cm. - Medical Doctor (MD) ordered on 2/4/25 indicated, .Treatment- Cleanse stage 3 pressure injury to coccyx with wound cleanser, pat dry and apply santyl [ointment that removes dead tissue] f/b [followed by] DSD [Director of staff Development]. Monitor for s/s [signs and symptoms] of infection, notify MD of any changes. every day shift for wound care . On 2/7/25 at 2:21 P.M., an interview and record review was conducted with the Minimum data set (MDS) nurse. The MDS nurse stated the admission assessment states open area to coccyx with measurements. I believe that ' s a pressure ulcer. The reason why is because they [admission nurses] are told to not stage it until the RN wound nurse is able to stage it if there is really a pressure ulcer. The MDS nurse stated that the pressure ulcer care plan as not in place within the 48-hour time frame and should be in place to indicate an actual pressure ulcer to help determine if the pressure ulcer got worse and to provide the proper treatment to promote healing. On 2/7/25 2:57 PM an interview was conducted with the Director of Nursing (DON). The DON stated, It was important to include an actual pressure ulcer on the admission assessment and the baseline care plan to prevent the pressure ulcer from worsening and delaying treatment to the pressure ulcer. The DON stated her expectations were for the initial admission assessments to be clear and note an actual pressure ulcer that indicated at the minimum if the skin was red or reddened as blanching [when skin appears paler or white after pressure is applied] or non-blanching [stays red] if they were unsure or stage the pressure ulcer according to what they [Registered Nurse] assessed. The DON further stated that the admission RNs should not wait for the wound RN to stage the pressure ulcer or wait until the wound RN initiated the actual pressure ulcer care plan within 48 hours to prevent worsening complications and delaying treatments. A review of the facility's policy and procedure titled PREVENTION OF PRESSURE ULCERS dated 2001, indicated .Assess the resident on admission (within eight hours) for existing pressure injury risk factors .Use facility-approved protective dressings for at risk individuals . 2. A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included a history of malnutrition (lack of proper nutrition). A record review of Resident 3's minimum data set (MDS - a federally mandated resident assessment tool) dated 1/29/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 3 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. A clinical chart review for Resident 3 was conducted, which indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER: Bayshire Torrey Pines Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 13101 Hartfield Ave San Diego, CA 92130	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The admission assessment titled, Skilled Nursing Initial Eval was conducted by a Registered Nurse [RN, LPN, LVN] on 1/23/25. - Admission ordered on 1/23/25 indicated, no treatment orders to the pressure ulcer on the coccyx. - Medical Doctor (MD) ordered on 1/29/25 indicated, - Treatment- Cleanse chronic stage 3 pressure injury to coccyx with wound cleanser, pat dry and apply santyl f/b calcium alginate and DSD. Monitor for s/s of infection, notify MD of any changes. every day shift for wound care . - Skin & Wound Evaluation 2/4/25: Coccyx Present on admission. Measurements area: 1.2 cm length 1.9 cm width 0.9 cm.stage 3 pressure injury to sacrococcyx [tailbone and the triangular shaped bone to the lower spine] . 2/7/25 at 2:10 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 3 ' s admission skin assessment dated [DATE] indicated, .Coccyx [tailbone] with small skin opening and quarter sized redness but was checked marked as a pressure ulcer. LN 1 stated the pressure ulcer care plan was initiated on 1/26/25 and should have been initiated within 48 hours (three days after admission). LN 1 stated it was important that the pressure ulcer care plan was in place within 48 hours to prevent delayed care and treatment for the pressure ulcer. LN 1 further stated delayed care can contribute to the worsening of pressure ulcers and infections if not cared for timely. On 2/7/25 at 2:38 P.M., an interview and record review was conducted with the Minimum Data Set (MDS) nurse. The MDS nurse stated Resident 3 ' s admission skin assessment dated [DATE] indicated Resident 3 had a pressure ulcer to the coccyx. The MDS nurse stated it was important that the pressure ulcer care plan was completed within 48 hours to provide a baseline description for the monitoring the pressure ulcer ' s status with interventions and/or worsening of the pressure ulcer and infection. On 2/7/25 2:57 PM an interview was conducted with the Director of Nursing (DON). The DON stated, It was important to include an actual pressure ulcer on the admission assessment and the baseline care plan to prevent the pressure ulcer from worsening and delaying treatment to the pressure ulcer. The DON stated her expectations were for the initial admission assessments to be clear and note an actual pressure ulcer that indicated at the minimum if the skin was red or reddened as blanching [when skin appears paler or white after pressure is applied] or non-blanching [stays red] if they were unsure or stage the pressure ulcer according to what they [Registered Nurse] assessed. The DON further stated that the admission RNs should not wait for the wound RN to stage the pressure ulcer or wait until the wound RN initiated the actual pressure ulcer care plan within 48 hours to prevent worsening complications and delaying treatments. A review of the facility's policy and procedure titled PREVENTION OF PRESSURE ULCERS dated 2001, indicated .Assess the resident on admission (within eight hours) for existing pressure injury risk factors .Use facility-approved protective dressings for at risk individuals .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Torrey Pines Post-Acute	13101 Hartfield Ave San Diego, CA 92130

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 48263

Based on observation, interview, and record review, the facility failed to accurately assess an actual pressure ulcer on admission, provide appropriate treatment and preventative measures according to standards of practice to prevent further progression of a pressure ulcer for one of 43 sampled residents (Resident 1) at risk for pressure ulcers.

This failure resulted in a delay of Resident 1's stage III pressure ulcer to be appropriately staged during an initial admission assessment and proper treatment for continous care necessary to prevent the worsening of the pressure ulcer.

Cross reference F655

Findings:

1. A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral infarction (a stroke that occurs when blood flow to the brain is blocked).

A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 1/14/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 1 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits.

On 2/7/25 at 1:52 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 1 ' s admission skin assessment on 2/1/25 indicated there was an open area to coccyx [tailbone] measures 1.5x1. 5. LN 1 stated that admission nurses do not stage pressure ulcers and wait until the wound Medical Doctor (MD) stages for them but are not always available during admissions to stage pressure ulcers. LN 1 stated Resident 1 ' s pressure ulcer risk assessment indicated a score of 17 (0-18) that indicated moderate risk (below 9 indicated high risk). LN 1 stated there was no actual pressure ulcer care plan until 2/4/25 (three days after admission) that was initiated by the wound RN. LN 1 stated this should have been included in Resident 1 ' s 48-hour baseline care plan if Resident 1 did have an actual pressure ulcer to prevent any worsening or delay in pressure ulcer care.

A clinical chart review for Resident 1 was conducted, which indicated:

- The admission assessment titled, Skilled Nursing Initial Eval was conducted by a Registered Nurse [RN] on 2/1/25.

- Admission Medical Doctor (MD) ordered on 2/1/25 indicated, .Treatment: Sacralcoccyxgeal [tailbone and the triangular shaped bone to the lower spine] open wound. Apply Barrier Cream To Area To Protect Skin For Maint [maintenance] Tx [treatment] x14 Days BID [twice daily] &PRN [as needed] every day and evening shift for (Skin Integrity Prevention) for 14 Days .

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER: Bayshire Torrey Pines Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 13101 Hartfield Ave San Diego, CA 92130	

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	- Skin & Wound Evaluation: 2/4/25 In-house Stage III Sacrum Present on admission. Measurements area: 0. 6cm length 1.2 cm width 0.6 cm. - MD ordered on 2/4/25 indicated, .Treatment- Cleanse stage 3 pressure injury to coccyx with wound cleanser, pat dry and apply santyl [ointment that removes dead tissue] f/b [followed by] DSD [Director of staff Development]. Monitor for s/s [signs and symptoms] of infection, notify MD of any changes. every day shift for wound care . On 2/7/25 at 2:21 P.M., an interview and record review was conducted with the Minimum data set (MDS) nurse. The MDS nurse stated the admission assessment states open area to coccyx with measurements. I believe that ' s a pressure ulcer. The reason why is because they [admission nurses] are told to not stage it until the RN wound nurse is able to stage it if there is really a pressure ulcer. The MDS nurse stated that the pressure ulcer care plan as not in place within the 48-hour time frame and should be in place to indicate an actual pressure ulcer to help determine if the pressure ulcer got worse and to provide the proper treatment to promote healing. On 2/7/25 2:57 PM an interview was conducted with the Director of Nursing (DON). The DON stated, It was important to include an actual pressure ulcer on the admission assessment and the baseline care plan to prevent the pressure ulcer from worsening and delaying treatment to the pressure ulcer. The DON stated her expectations were for the initial admission assessments to be clear and note an actual pressure ulcer that indicated at the minimum if the skin was red or reddened as blanching [when skin appears paler or white after pressure is applied] or non-blanching [stays red] if they were unsure or stage the pressure ulcer according to what they [Registered Nurse] assessed. The DON further stated that the admission RNs should not wait for the wound RN to stage the pressure ulcer or wait until the wound RN initiated the actual pressure ulcer care plan within 48 hours to prevent worsening complications and delaying treatments. A review of the facility's policy and procedure titled PREVENTION OF PRESSURE ULCERS dated 2001, indicated .Assess the resident on admission (within eight hours) for existing pressure injury risk factors .Use facility-approved protective dressings for at risk individuals .