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	12/12/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270 Based on observation, interviews, and record review, the facility did not ensure it followed professional standards of practice when a gastrostomy tube (GT-tube inserted through the belly to bring nutrition and medications directly to the stomach) placement and residual (the amount of liquid drained from a stomach following administration of nutrition) was not checked before medication administration for one resident (20). This failure had the potential for causing complications related to GT health. Findings: Per the facility face sheet, Resident 20 was admitted to the facility on [DATE] with diagnoses that included gastrostomy status (presence of an artificial opening into the stomach). On 12/11/24 at 8:22 A.M., licensed nurse (LN) 1 was observed and interviewed during a medication administration for Resident 20. On 12/11/24 at 8:31 A.M., LN 1 entered Resident 20's room. LN 1 explained the procedure to Resident 20 and detached Resident 20's GT from the nutrition feeding tube. LN 20 attached a syringe to the GT and flushed the GT with water. LN 20 then proceeded to administer medications. On 12/11/24 at 8:45 A.M., LN 1 stated she was done with administering Resident 20's medication. LN 1 stated, I forgot to check the GT placement and residual prior to giving the medications. On 12/12/24 at 2:00 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation that all nurses check GT placement and residual prior to administering medications and that it is important in order to help prevent complications such as aspiration pneumonia. A review of the facility policy titled, Administering Medications through an Enteral Tube dated November 2018, .6. Verify placement of feeding tube .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 provide nail care to one of two residents (Resident 96), reviewed for Activities of Daily Living (ADL, activities related to personal care) for dependent residents. As a result, Resident 96 was at risk for skin injury and infection. Findings: Resident 96 was admitted to the facility on [DATE], with diagnoses which included generalized muscle weakness and needed assistance for personal care, per the facility's Admission Record. On 12/9/24 at 4:03 P.M., an observation and interview were conducted for Resident 96 as she laid in bed. Resident 96's arms and hands were exposed, and fingernails appeared long, split and with brown materials underneath the nails. Resident 96 stated, No one asked if I want my nails cut short, I want it trimmed but no one asked me. They (facility staff) see it. On 12/10/24, Resident 96's clinical record was reviewed. A review of Resident 96's History and Physical (H&P) dated 11/30/24, indicated Resident 96 had fluctuating capacity to make her own medical decisions. A review of Resident 96's minimum data set (MDS - a federally mandated resident assessment tool), dated 12/3/24, Resident 96 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 11/15, (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). The functional status indicated Resident 96 required one to two-person (staff member) assistance for hygiene and grooming. A review of Resident 96's care plan (directs the plan of care for the residents that included the goal and interventions), dated 11/28/24, indicated one of the goals for Resident 96's ADLs included provide grooming and hygiene daily . On 12/10/24 at 4:24 P.M., a follow up observation and an interview were conducted for Resident 96 as she laid in bed. Resident 96 pointed her right thumb fingernail, stated the facility staff did not trim her fingernails, and there was a split between her fingernails. Resident 96 stated she was not comfortable about the split in her fingernail. Resident 96 stated There is something underneath it and they have to trim so that it will not split. On 12/10/24 at 4:33 P.M., a joint observation of Resident 96's fingernails and an interview with Certified Nursing Assistant (CNA) 11 were conducted. CNA 11 stated the CNAs spent the most time with the residents when providing care, and should have checked Resident 96's fingernails. CNA 11 stated Resident 96's fingernails were long and needed to be trimmed. CNA 11 stated Resident 96 might scratch herself with long fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 4:50 P.M., a joint observation of Resident 96's fingernails and an interview with Licensed Nurse (LN) 11 were conducted. LN 11 stated LNs did the assessment to newly admitted residents and one of their responsibilities was to check the residents' fingernails. LN 11 stated Resident 96's fingernails were long, curling and with brown materials underneath the fingernails. LN 11 stated Resident 96's fingernails needed to be trimmed. LN 11 stated the brown materials underneath Resident 96's fingernails could have been a food debris. LN 11 stated it was important to trim the residents' fingernails because they might scratch themselves and if something was in the fingernails, it might cause an infection to the residents. On 12/12/24 at 1:59 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectations was for the facility staff to ensure the residents' fingernails were cleaned and trimmed as part of the hygiene provided to the residents. A review of the facility's undated policy titled, Activities of Daily Living (ADL), Supporting, 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 .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270 Based on observation, interview and record review, the facility did not ensure a dressing for a peripherally inserted central catheter (PICC- a long, thin, flexible tube inserted into a vein that allows delivery of medications) was changed in a timely manner for one resident (151). This failure had the potential to increase the risk of infection to Resident 151. Findings: Per the facility face sheet, Resident 151 was admitted to the facility on [DATE] with diagnoses that included pelvic osteomylitis (infection of the bone). On 12/9/24 at 3:56 P.M., an observation and interview was conducted with Resident 151 in the resident's room. Resident 151 was sitting in the wheelchair watching TV. An observation of a PICC line on the resident's left upper arm covered with a dressing dated 12/1/24. Resident 151 stated that the dressing had not been changed since the nurse at the hospital did. On 12/12/24 at 2:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 151's PICC line dressing should have been changed on 12/8/24 and that it was her expectation that all dressings be changed according to standards of practice and facility policy. A review of the facility policy titled, Peripheral and Midline IV Dressing Changes dated March 2023, indicated that IV dressings need to be changed .a. at least every 7 days .

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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	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and record review, the facility failed to indicate the appropriate indication for the use of anticoagulant (blood thinner) medication for one of two residents (Resident 22), reviewed for unnecessary medications. This had the potential for unnecessary medication use and had the potential to negatively impact the resident's well-being. Findings: A review of Resident 22's Admission Record indicated Resident 22 was admitted to the facility on [DATE], with diagnoses which included peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs) and atrial fibrillation (A-fib, irregular and rapid heartbeat). A review of Resident 22's physician order dated 11/9/22 indicated the following order: - Apixaban (blood thinner medication) for anticoagulant. On 12/10/24 at 4:33 P.M., a concurrent review of Resident 22's clinical record and an interview with Licensed Nurse (LN) 12 was conducted. LN 12 stated Resident 22 had been in the facility since 11/9/22. LN 12 stated there was a physician's order of apixaban for Resident 22 on 11/9/22 and the indication for its use was for anticoagulant. LN 12 stated the LN who transcribed the order no longer worked in the facility. LN 12 stated there should be a clear indication for the use of apixaban whether it's for A-fib or PVD for Resident 22. LN 12 stated the LNs should have verified with the attending physician what was the apixaban intended for. On 12/12/24 at 1:59 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the LNs to verify the order from the physician and clarify the indication for the medication and the intended use of it. A review of the facility's policy titled, Medication Orders, revised 10/2018, indicated, .B. Completeness of Orders .1 .Orders must include the drug .It is also recommended that the indication/diagnosis for use be included on each order .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interviews, and record review, the facility failed to indicate the appropriate use of anti-anxiety (medication used for worry and fear) medications and communicated the target behavioral monitoring for the use of anti-anxiety medication among staff members, for one of five residents reviewed for unnecessary psychotropic (mind-altering) medications (Resident 96). This failure had the potential for unnecessary psychotropic medication use, its side effects, and a decline for residents psychological and mental well-being. Findings: A review of Resident 96's Admission Record indicated Resident 96 was admitted to the facility on [DATE]. A review of Resident 96's physician order dated 11/28/24 indicated the following order: - Clorazepate (an anti-anxiety medication) for psychosis. - Monitor episodes of (.psychosis .AEB [sic, as evidenced by]: hallucinations, agitation) .for drug use of clorazepate. On 12/10/24 at 4:33 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11, outside Resident 96's room. CNA 11 stated she was familiar with Resident 96. CNA 11 stated Resident 96 had no behaviors, and no behavior monitoring was reported for them (the staff) to observe. On 12/11/24 at 10:02 A.M., an interview was conducted with CNA 12, outside Resident 96's room. CNA 12 stated Resident 96 was a nice resident and there was no behavioral monitoring conducted for Resident 96. CNA 12 stated the nurses will tell us if they (residents) need to have any behavioral monitoring. On 12/11/24 at 12:12 P.M., a concurrent review of Resident 96's clinical record and an interview was conducted with Licensed Nurse (LN) 12. LN 12 stated she admitted Resident 96 to the facility on [DATE]. LN 12 stated Resident 96 had a physician's order of clorazepate and was indicated for psychosis. LN 12 stated Resident 96 had no diagnosis of psychosis. LN 12 stated clorazepate was an anti-anxiety medication. LN 12 stated the indication of the clorazepate is not the right diagnosis, it is important to know the right indication because with this one, it is not the right behavior that we are targeting. LN 12 stated it was important to specify the indication to prevent confusion and unnecessary drug use. LN 12 stated she put the order, Wrong. In addition, LN 12 stated she did not know where to find the documentation for the behavioral monitoring related to the use of clorazepate for Resident 96. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 1:59 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the LNs to clarify the indication of psychotropic medication. The DON stated it was important to know why the residents were taking the medications and what disease process the residents were treated for. A review of the facility's undated policy, titled Psychotropic Medication Use, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: .c. Anti-anxiety medications .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 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. Opened food items had no use by date. 2. Food items with mold in it. 3. Employees' personal belongings were stored inappropriately in a food preparation area. 4. Boxes on top of the ice machine. 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 [DATE] at 8:40 A.M., an observation was conducted with the Certified Dietary Manager (CDM) in the walk-in refrigerator. These observations included: - sweet and sour basting sauce with no use by date - grated carrots with no use by date - salsa with no use by date - noodle soup with no use by date - tomato soup with no use by date On [DATE] at 11:09 A.M., an interview was conducted with the CDM. The CDM stated it was important to label and indicate the use by date on the food items to ensure residents were not served with expired foods for safety, and protocols were taken to ensure susceptible residents were free from harm related to food consumption. On [DATE] at 1:45 P.M., an interview was conducted with the Registered Dietician (RD) with the presence of the Administrator (ADM) and the Director of Nursing (DON). The RD stated the expectation was for the dietary staff to conduct quick inspection, label, and indicate the use by date to ensure residents were not served expired foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].17 (A) (B) (C) (D), .required food labeling and dating .the day the original container is opened .The date marked shall not exceed a manufacturer's use by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. A review of the facility's policy, titled Food Storage, revised [DATE], indicated, .All products should be .dated upon receipt, when open and when prepared. Use Use-By dates on all food stored in refrigerators . 2. On [DATE] at 8:40 A.M., an observation was conducted with the CDM in the walk-in refrigerator. There were two packs of strawberries with mold in it. The CDM stated, I don't know what to say. On [DATE] at 11:09 A.M., an interview was conducted with the CDM. The CDM stated it was important to inspect the food items in the refrigerator to ensure the residents were served fresh fruits and free from harm related to food consumption. On [DATE] at 1:45 P.M., an interview was conducted with the RD with the presence of the ADM and the DON. The RD stated the expectation was for the dietary staff to check the fruits to ensure they were fresh because it was a health risk to the residents. A review of the facility's policy, titled Food Storage, revised [DATE], indicated, .All products should be inspected for safety and quality .Fresh Fruits, 1. Fresh fruit should be checked . 3. On [DATE] at 8:40 A.M., an observation was conducted with the CDM in the food preparation area. There was a cellphone, keys, and speaker by the food tray. Next to these items was a gallon of corn syrup. On the other side, was a tray of bread. On [DATE] at 11:09 A.M., an interview was conducted with the CDM. The CDM stated the employees' personal belongings should be kept in the lockers and should not be in the food preparation area to prevent food contamination. On [DATE] at 1:45 P.M., an interview was conducted with the RD with the presence of the ADM and the DON. The RD stated the expectation was for the dietary staff to keep their personal belongings in the designated location to prevent food contamination, which may cause illness to the residents. According to the 2017 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].11(B), . Storage of personal items: Lockers or other suitable facilities are to be provided for the storage of employee personal possessions, ,d+[DATE].11 (b) - lockers or suitable facilities are to be located in a designated area where contamination of food, equipment, utensils cannot occur . A review of the facility's policy, titled Personal Hygiene/Safety/Food Handling/Infection Control, revised [DATE], indicated, .5. Designated Area for Employee Personal Belongings .b. Personal belongings .may be stored in the designated area . 4. On [DATE] at 8:40 A.M., an observation and an interview was conducted with the CDM in the food preparation area. There were two boxes of Styrofoam products on top of the ice machine. The CDM stated, The boxes should not be there. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:09 A.M., an interview was conducted with the CDM. The CDM stated the boxes were removed on top of the ice machine. The CDM stated, The kitchen should be clutter free as a best practice. On [DATE] at 1:45 P.M., an interview was conducted with the RD with the presence of the ADM and the DON. The RD stated, The expectation was the ice machine should be completely clear to keep the ice machine sanitized because there might be a debris that may fall in the ice machine which could create mold because mold builds up very quickly. According to the 2017 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].11, Equipment .Food-Contact Surfaces .indicate, .(A) Equipment Food-Contact Surfaces .shall be clean .

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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** 40610 Based on observation, interview, and record review, the facility failed to ensure safe infection control practices when a urinary catheter (a tube inserted into the bladder to aid in urine flow) bag and dignity bag (a bag used to cover and conceal contents inside) was lying on the floor for one of two residents reviewed for urinary catheter care (Resident 95). This failure had the potential for cross contamination (spread of germs and bacteria) and infection. Findings: A review of Resident 95's Admission Record indicated Resident 95 was admitted to the facility on [DATE], with diagnoses which included benign prostatic hyperplasia (BPH, a condition in which the prostate gland is larger than normal and may block the bladder and the urethra) with urinary tract symptoms. A review of Resident 95's history and physical (H&P) dated 11/29/24, indicated he had the capacity to make his own medical decisions. The H&P indicated Resident 95 had chronic urinary retention due to BPH with chronic urinary catheter. A review of Resident 95's minimum data set (MDS - a federally mandated resident assessment tool), dated 12/5/24, Resident 95 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 15/15, (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). The MDS section for bowel and bladder indicated Resident 95 had a urinary catheter upon admission. On 12/9/24 at 3:14 P.M., an observation and an interview with Resident 95 was conducted in his room. Resident 95 laid in bed with a urinary catheter visible next to the bed. Resident 95's catheter bag and privacy bag were on the floor. Resident 95 stated he was, Not comfortable. On 12/9/24 at 3:18 P.M., an observation with Licensed Nurse (LN) 14 was conducted. LN 14 administered medication to Resident 96. After giving Resident 96 his medications, LN 14 jumped over the catheter bag and the privacy bag which were on the floor. On 12/9/24 at 3:22 P.M., an interview was conducted with LN 14. LN 14 stated the catheter bag should have been hung and not laid on the floor to prevent from accidentally pulling the catheter which may cause trauma, and prevent bacteria to enter the catheter bag which may cause an infection to Resident 95. On 12/10/24 at 2:22 P.M., an interview was conducted with the Infection Preventionist (IP). The IP stated the urinary catheter, and the privacy bag should be always off the floor to prevent infection to the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 1:59 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated there should be no catheter bag on the floor for infection control purposes. The DON stated, That should not happen. A review of the facility's policy titled Catheter Care, Urinary, dated 2001, indicated, .Infection Control .2. Be sure the catheter tubing and drainage bag are kept off the floor .