STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555873	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Bay Post Acute Care	553 F Street Chula Vista, CA 91910

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 interview and record review, the facility failed to ensure physician (MD) ordered wound care treatments for pressure ulcer ((localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) were implemented as directed for one of three sampled residents (Resident 1). As a result, Resident 1's pressure ulcer on the sacrum (the base of the spine or simply the bottom of the back) increased in size and placed Resident 1 at risk for worsening skin integrity, potential infection, delayed healing, and further complications related to pressure ulcer progression.Findings: A review of Resident 1's admission Record indicated Resident 1 was re-admitted to the facility on [DATE] (initial admission 2/8/26-2/24/26) with diagnoses which included history of Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 1's Minimum Data Set (MDS- nursing facility assessment tool) dated 3/26/26 indicated that Resident 1 had memory problems with Physician progress note dated 2/20/26 indicated, .UTA [unable to assess] fully due to confusion. A record review of Resident 1's Minimum Data Set (MDS- nursing facility assessment tool) dated 3/29/26 indicated, Resident 1 had moderate cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits with poor decision making and required cues/supervision. On 4/13/26 at 11 A.M., an interview and record review was conducted with the Wound Nurse (WN). The wound nurse stated that Resident 1's initial admission [DATE]) included a skin assessment on the sacrum as an open wound that measured 3 cm (centimeters) by 3 cm. The wound nurse stated that rounds with the Wound Physician (MD) were completed on a weekly basis.The first Wound MD notes dated 2/10/26 indicated, Resident 1 had a deep tissue pressure injury (a pressure injury is localized damage to the skin and underlying soft tissue when there isn't an open wound, but the tissues beneath the surface have been damaged that can look like a bruise) that measured .Sacrum: 7.5 [centimeters] x2x0 Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration. Weekly Instructions from the Wound MD notes on 2/8/26 through 2/24/26 indicated, .Primary Dressing/ Apply.Calcium alginate [natural, seaweed-based dressing used to treat heavily draining wounds] - to sacrum.Medihoney [medical-grade honey intended for wound care] gel - to sacrum.Dressing/Apply or cover with.Foam dressing.Dressing Change/Application Frequency. Daily.and as needed.Support Surface Group 2 mattress [i.e. low air-loss (LAL- designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) mattress]. Wound MD measurements on 2/17/26 to the sacrum indicated, .Sacral 3.2x1.9x0 Area 6.08. Wound MD measurements on 2/24/26 to the sacrum indicated, a wound size of .3.5x4x0. The WN stated that Resident 1's wound MD instructions were not carried out as instructed for the month of February 2026. The WN stated it was important that wound care recommendations/instructions and follow up treatments were carried out as directed to prevent further deterioration of Resident 1's sacrum pressure ulcer, reduce the risk of complications, and promote wound healing. The WN stated that Resident 1's diabetes (elevated blood glucose) contributed to impaired circulation and decreased tissue perfusion (flow of blood to tissues and organs), which placed Resident 1 at increased risk for delayed healing and worsening of the pressure (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury when treatments were not implemented as ordered. A record review of Resident 1's treatment orders for pressure ulcer management indicated: .Low air loss mattress therapeutic for skin management and comfort with setting as manufacture and as tolerated by the resident. Check placement and functioning for skin management every shift ordered 3/15/26. A record review of Resident 1's treatment orders for the sacrum pressure ulcer indicated: .Sacrum pressure injury. Cleanse site with quarter strength dakins sol (highly diluted, specialized bleach mixture to clean wounds), pat dry, apply medihoney, cover with calcium alginate and foam dressing. every day shift for WOUND MANAGEMENT ordered 3/01/26. A record review of Resident 1's Wound MD notes dated 3/24/26 to the sacrum pressure ulcer indicated, measurements .Sacral [sacrum] 13x10.5x0 Area 136.5 Unstageable Pressure Injury (a full-thickness tissue loss where the wound base is obscured by necrotic tissue (slough or eschar). On 4/11/26 at 3 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated MD ordered wound treatments were expected to be implemented as directed, based on the Wound MD's assessment and treatment plan. The DON stated that timely initiation and consistent implementation of ordered wound care were important to prevent complications, including worsening size, infection, and delayed healing. The DON further stated Resident 1's hospital history, the resident was evaluated for palliative (specialized medical care focused on providing relief from the symptoms, pain, and stress of a serious illness) care prior to the first admission [DATE]); however, ordered treatments were still required to be implemented to promote optimal skin integrity and prevent avoidable deterioration of the pressure injury. A review of the facility's policy and procedure titled, Policy / Procedure - Nursing Administration-Wound Management (undated), indicated .Treatments ordered by the physician will be used as ordered. If no improvement, the physician will be called for an evaluation