STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055761	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encinitas Nursing and Rehabilitation Center	900 Santa Fe Drive Encinitas, CA 92024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51631 Based on interview and record review, the facility failed to protect one resident (Resident 2) from physical abuse when Resident 1, who had a history of wandering, wandered into the dining hall unsupervised and hit Resident 2 on the arm. This deficient practice had the potential for Resident 2 and other residents to feel unsafe in the facility. Findings: A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease (a progressive irreversible brain disorder that causes memory and thinking skills to decline) and delirium (mental state characterized by confusion, disorientation, and inability to think). On 11/7/24 at 9:30 A.M., an onsite visit was conducted to investigate a facility reported allegation of abuse that occurred on 11/3/24 between Resident 1 and Resident 2. A review of Resident 1's interdisciplinary team (IDT) note dated 11/7/24, indicated, .Event: On 11/03/24 [Resident 2] reported that this resident allegedly ' hit' another female resident's LUE [left upper extremity] in the dining room. Prior to incident: [Resident 1] was last seen propelling in the hallway . Determination: After investigation and interview, IDT determined that [sic] incident of abuse occurred A review of Resident 1's care plan for elopement dated 8/16/24, indicated, .[Resident 1] wheels about aimlessly . enters others' room and explores others' belongings A review of Resident 1's care plan for mood dated 9/17/24, indicated, .[Resident 1] has a behavior problem aeb [as evidenced by] physically aggressive towards others, being agitated, anxious, restless, having delusions, rummaging (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Social Services assessment dated [DATE], indicated, .Resident interests/hobbies . wandering around in her wheelchair On 11/7/24 at 10:05 A.M., an interview was conducted with Resident 2. Resident 2 stated she was having a private conversation with another resident in the dining hall after dinner (on 11/3/24). Resident 2 stated Resident 1 came into the dining hall in her wheelchair and intruded upon their conversation and started taking food off their dinner trays. Resident 2 stated they told Resident 1 the food was not hers and to not touch it. Resident 2 stated that Resident 1 began yelling and then hit her hard on the arm. Resident 2 stated, I was mortified when it happened. Resident 2 stated staff were not present, and she had to use her cell phone to call for staff assistance. Resident 2 stated a certified nursing assistant (CNA) came and removed Resident 1 from the dining hall. Resident 2 stated Resident 1 had a habit of wandering into her room and other residents' rooms and took personal items. Resident 2 stated staff told her there was nothing they could do about Resident 1's behavior of wandering around. On 11/7/24 at 10:25 A.M., an interview was conducted with a confidential resident (CR) 3. CR 3 stated Resident 1 frequently wandered into his room, and he did not feel safe. CR 3 stated he was sometimes uncomfortable sleeping because he was worried Resident 1 would come into his room. CR 3 stated Resident 1 intruded during mealtimes by wandering around and taking residents' food. CR 3 further stated, No one watches [Resident 1] . they need to put a CNA on her. On 11/7/24 at 11:40 A.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 had to have staff assistance to get into her wheelchair and could not do that independently. CNA 4 stated once Resident 1 was in her wheelchair, the resident would go around the facility room to room. CNA 4 stated Resident 1's behavior of wandering caused altercations between residents and could lead to abuse. CNA 4 stated Resident 1 needed 1:1 supervision (one staff assigned to the resident at all times) when up in her wheelchair to prevent this behavior from happening. On 11/7/24 at 11:55 A.M., an interview was conducted with the activity assistant (AA) 6. AA 6 stated Resident 1 could be aggressive and that she had observed the resident kick at others who told her not to do something. AA 6 stated Resident 1 wandered all around and entered other resident rooms. AA 6 stated the other residents did not like that and there were times these incidents caused fights and altercations between residents. On 11/7/24 at 12:10 P.M., an interview was conducted with CNA 5. CNA 5 stated Resident 1 had, A big problem with wandering. CNA 5 stated Resident 1 would go into other residents' rooms and take personal items. CNA 5 stated Resident 1 would become agitated when told the item did not belong to her. CNA 5 stated Resident 1 required 1:1 supervision when up in her wheelchair to prevent this. On 11/7/24 at 2:10 P.M., an interview was conducted with licensed nurse (LN) 7. LN 7 stated Resident 1 wandered, entered other residents' rooms, and took personal items. LN 7 stated this was an unsafe behavior that could lead to altercations between residents and/or abuse. LN 7 stated Resident 1, Needs constant redirection when up in wheelchair which requires someone to be there constantly. LN 7 stated Resident 1 should have been on 1:1 supervision when up in her wheelchair for everyone's safety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 4:40 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 1's intrusive behavior, wandering into other rooms, and rummaging could lead to altercations and potential abuse. The DON stated Resident 1's plan of care should have included increased supervision to prevent further incidents from occurring. A review of the facility's policy titled Alleged or Suspected Abuse Crime Reporting revised 10/2022, indicated, Each resident has the right to be free from abuse . 4. Prevention .Identifying, correcting and intervening in situations in which abuse .is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure staff assigned have knowledge of the individual residents' care needs and behavioral symptoms . The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51631 Based on interview and record review, the facility failed to ensure written care plans for one resident (Resident 1) were resident specific to include interventions that addressed the resident's need for increased supervision when up in her wheelchair and wandering the facility. As a result of this deficient practice, Resident 1 was able to wander around the facility unsupervised which caused altercations with other residents and led to an incident of physical abuse (cross reference F600). Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease (a progressive irreversible brain disorder that causes memory and thinking skills to decline) and delirium (mental state characterized by confusion, disorientation, and inability to think). On 11/7/24 at 9:30 A.M., an onsite visit was conducted to investigate a facility reported allegation of abuse that occurred on 11/3/24 between Resident 1 and Resident 2. A review of Resident 1's interdisciplinary team (IDT) note dated 11/7/24, indicated, .Event: On 11/03/24 [Resident 2] reported that this resident allegedly ' hit' another female resident's LUE [left upper extremity] in the dining room. Prior to incident: [Resident 1] was last seen propelling in the hallway . Determination: After investigation and interview, IDT determined that [sic] incident of abuse occurred A review of Resident 1's care plan for elopement dated 8/16/24, indicated, .[Resident 1] wheels about aimlessly . enters others' room and explores others' belongings A review of Resident 1's care plan for mood dated 9/17/24, indicated, .[Resident 1] has a behavior problem aeb [as evidenced by] physically aggressive towards others, being agitated, anxious, restless, having delusions, rummaging On 11/7/24 at 11:40 A.M., an interview was conducted with certified nursing assistant (CNA) 4. CNA 4 stated Resident 1 had to have staff assistance to get into her wheelchair and could not do that independently. CNA 4 stated once Resident 1 was in her wheelchair, the resident would go around the facility room to room. CNA 4 stated Resident 1's behavior of wandering caused altercations between residents and could lead to abuse. CNA 4 stated Resident 1 needed 1:1 supervision (one staff assigned to the resident at all times) when up in her wheelchair to prevent this behavior from happening. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 2:10 P.M., a joint interview and record review was conducted with licensed nurse (LN) 7. LN 7 stated Resident 1 wandered, entered other residents' rooms, and took personal items. LN 7 stated this was an unsafe behavior that could lead to altercations between residents and/or abuse. LN 7 stated Resident 1, Needs constant redirection when up in wheelchair which requires someone to be there constantly. LN 7 stated Resident 1 should have been on 1:1 supervision when up in her wheelchair for everyone's safety. LN 7 reviewed Resident 1's written care plans and stated the constant supervision and 1:1 the resident required when up in her wheelchair was not in the care plans. LN 7 stated that was an individualized intervention to prevent the unsafe wandering and should be in the resident's written care plans. On 11/7/24 at 2:50 P.M., an interview was conducted with LN 8. LN 8 stated Resident 1 had a behavior of wandering in the hallway unattended. LN 8 stated Resident 1's unsupervised wandering could lead to altercations and potential abuse. LN 8 stated in order to keep Resident 1 and other residents safe, Resident 1 should have had 1:1 supervision while in her wheelchair. LN 8 stated this intervention should have been included in Resident 1's individualized care plan. On 11/7/24 at 4:40 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 1's intrusive behavior, wandering into other rooms, and rummaging could lead to altercations and potential abuse. The DON stated Resident 1's plan of care should have included increased supervision to prevent further incidents from occurring. A review of the facility's policy titled Care Plan, Comprehensive dated December 2017, indicated, .1. Care plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs