STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056496	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlsbad by the Sea	2855 Carlsbad Blvd 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 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** 45909 Based on interview and record review, the facility failed to ensure a care plan for hard of hearing (HOH - Hard of hearing) was developed for one out of one sampled resident (Resident 131). This failure had the potential for Resident 131 not to receive the appropriate care. Findings: Resident 131 was admitted to the facility on [DATE] with diagnoses which included fall, back pain, hypertension (high blood pressure) per the facility's Admission Record. During an interview with Resident 131's daughter on 12/3/24 at 9:12 A.M. The daughter stated, Resident 131 was HOH and was concerned of Resident 131's safety. During a concurrent interview and record review with licensed nurse (LN) 1 on 12/4/24 at 2:45 P.M. LN 1 stated, Resident 131 did not have a care plan for HOH. LN 1 further stated a care plan for HOH should have been initiated upon admission by the nursing staff to properly address Resident 131's communication needs. During an interview with the Director of Nursing (DON) on 12/5/24 at 10:30 A.M. The DON stated, residents assessed with HOH should have a care plan for staff to address the communication needs. The DON further stated, Resident 131's HOH care plan should have been initiated upon admission for nursing staff to provide Resident 131 safety and care. Review of the facility's policy titled, Care Planning, revised 2/2021, indicated, PROCEDURE .2c Care plan problems include existing difficulties as well as potential problems as identified - sensory impairment.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to provide staff supervision during an Activity of daily Living (ADL - everyday task) for one of three sampled residents (Resident 7) when Resident 7 was observed using a disposable razor. This failure had the potential to affect Resident 7's well- being. Findings: Resident 7 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (A fib - irregular heart rate), congestive heart failure (CHF - heart failure) per Admission Record. During a concurrent observation and interview with Resident 7 on 12/3/24 at 11:45 A.M. Resident 7 was observed shaving her chin unsupervised by facility staff with a disposable razor. Resident 7 stated, she shaves her chin everyday by herself. During a concurrent interview and record review with licensed nurse (LN) 1 on 12/4/24 at 11:30 A.M. Resident 7's nursing care plan (NCP - document with the appropriate nursing care) dated 11/14/24 indicated, Resident 7 was at risk for excessive bleeding related to the use of a blood thinner (medication to treat A- fib). LN 1 stated per NCP, Resident 7 should have been provided with an electric razor and not a disposable razor. LN 1 further stated, Resident 7 should have been supervised while Resident 7 was shaving herself to prevent Resident 7 from an accidental cut and bleeding. During an interview with the Director of Nursing (DON) on 12/5/24 at 8:25 A.M., the DON stated nursing staff should follow the NCP. The DON further stated Resident 7 should have been provided with an electric razor and should have been supervised by a nursing staff while Resident 7 was shaving to prevent an accidental cut and bleeding. Review of the facility's policy titled ADL CARE dated 12/2019, indicated, POLICY. Nursing staff will provide ADL care to each resident daily to meet their individual needs. PROCEDURE: 4. Assist resident as needed with activities of daily living according to resident's plan of care.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45909 Based on observation, interview and record review, the facility failed to ensure all medications were locked for one of two medication carts (Medication Cart #1). This failure had the potential for Medication Cart #1 to be accessed by unauthorized personnel. Findings: An observation was conducted on 12/4/24 at 7:58 A.M. in the hallway by the nursing station. Medication Cart #1 was noted unlocked and unattended by a Licensed Nurse (LN). A concurrent observation and interview was conducted on 12/4/24 at 8:03 A.M. with Licensed Nurse (LN) 1. LN 1 was observed inside the medication room. LN 1 later exited the medication room and went to Medication Cart # 1. LN 1 stated medication cart #1 was left unlocked and unattended when she went to the medication room. LN 1 opened the drawers of Medication Cart # 1 that contained medications without unlocking it with a key. LN 1 stated the key lock button should have been pushed to lock the medication cart. LN 1 stated she should have locked the Medication Cart # 1, when she went inside the medication room to prevent unauthorized people to gain access to the medications. An interview was conducted on 12/5/24 at 8:29 A.M. with the Director of Nursing (DON). The DON stated medication carts should be locked when unattended. The DON further stated it was important to ensure that medication carts were locked to prevent unauthorized access to the medication, for patient safety and for prevention of drug diversion. Review of the facility's policy titled Medication Storage dated 1/2023, indicated, PROCEDURES .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.

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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** 43518 Based on observation, interview, and record review the facility failed to store food safely when it: 1. Left a vegan meatball, fruit, vegetables, and other food debris under prep table for 2 days. 2. Did not label the facility's dry, frozen, and refrigerated foods with the month, the day, and the year. 3. Did not clean up loose sugar from the bottom of a box of sugar packets in the dry storage room. 4. Did not refrigerate soy sauce and orange sauce after opening per manufacturer's guidelines on sauces' labels. 5. Did not cover precooked shrimp in a sealed container in the middle section of the walk-in refrigerator. These failures had the potential for foodborne illness and pests. Findings: On [DATE] at 8:35 A.M., the initial tour of the facility's kitchen was conducted with the Director of Dining Services (DDS). On [DATE] at 8:40 A.M., during the initial tour of the kitchen, a brown ball resembling a meatball, broccoli, strawberry stems, a blueberry, and various crumbs were observed under a prep table in the center of the kitchen. On [DATE] at 8:49 A.M., an observation of the first walk-in fridge and interview with C1 was conducted. A metal container in the center shelf of refrigerator was observed with cooked shrimp half covered by plastic wrap. Chef (C1) stated that they were serving shrimp salad for lunch and they were prepping it that morning. C1 stated the importance of storing the shrimp in a sealed container was to prevent contamination and prevent foodborne illness. On [DATE] at 8:54 A.M., an observation of the first dry storage room and interview with C1 & the DDS was conducted. All boxes of food products were observed to be labeled with only the month and the day of opening. C1 stated that they go through the dry goods fast so they only label with month and day. C1 stated that the importance of labeling with year is to make sure to maintain food quality and prevent serving expired food. An opened Sauce for Orange Chicken dated ,d+[DATE] and soy sauce dated ,d+[DATE] were observed in dry storage. Both sauces' labels indicated REFRIGERATE AFTER OPENING FOR QUALITY. C1 stated he was not aware these sauces had to be refrigerated after opening. The DDS stated that he was not aware that these sauces had to be refrigerated after opening either and threw both sauces in garbage. (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 9:01 A.M., an observation of the second dry storage room and interview with C1 was conducted. Sugar packets in cardboard box were observed with loose sugar all around the packets. C1 stated that he didn't know the sugar box had loose sugar at the bottom of it. C1 stated that sugar should be contained in packet or sealed container to prevent attraction of pests. On [DATE] at 9 A.M., an observation of walk-in freezer and interview with the DDS was conducted. Boxes labeled with only month and day were observed all throughout the freezer. The DDS stated that he had been changing the dates in dry storage the day before, but he had not been able to get in the freezer. On [DATE] at 9:10 A.M., an observation of food prep area and interview with the DDS was conducted. Observed same brown ball resembling a meatball, various food debris, and small cup under prep table from the day before. DDS picked the ball up from the floor and stated that it was a vegan meatball from Monday on [DATE]. On [DATE] at 1 P.M. an interview was conducted with the DDS. The DDS stated that the expectation was the kitchen should be cleaned daily and there should be no debris under the table. The DDS stated the importance of keeping the area under the prep tables clean was pest prevention. The DDS stated that the expectation was all food should be labeled with received date and expiration date, including month, day, and year. The DDS stated the importance of accurate labeling was to preserve the quality of food, and to prevent food born illness from expired food. The DDS stated that the expectation for perishable foods (i.e. shrimp) should be stored in a sealed container when in the refrigerator. The DDS stated that the importance of storing perishable food in sealed container is to prevent contamination of food and the spread of foodborne illness. The DDS stated that the expectation is that sugar packets should be intact, and there should be no loose sugar in storage area. The DDS stated the importance of storing sugar in sealed container or in sealed individual packets was pest prevention. The DDS stated the expectation for storage of sauces was to follow manufacturer's guidelines on the label of individual sauces. The DDS stated the importance of following manufacturer's guidelines is to prevent foodborne illness from improperly stored sauces. On [DATE] at 1:45 P.M., a concurrent observation of photos from kitchen task and interview with the Executive Director (ED) was conducted. The ED stated that the expectation for cleaning prep area was that staff should clean under table daily. The ED state the importance of daily cleaning was pest prevention. The ED stated that the expectation for food labeling was that all food should be labeled with full date including month, day, year. The ED stated that the importance of accurate labeling was to preserve food quality and prevent foodborne illness from spoiled food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ED stated the expectation for sugar storage in dry storage room is that there should be no loose sugar, and all sugar packets should be intact. The ED stated the importance of proper sugar storage was pest prevention. The ED stated that all sauces should be stored according to manufacturer's guidelines. The ED stated the importance of proper storage was to prevent foodborne illness. The ED stated that perishable food like shrimp should be in a covered and sealed container in the refrigerator. The ED stated the importance of storing perishable food in a seal container was to prevent contamination and prevent food borne illness. Review of facility policy titled FOOD STORAGE dated [DATE] indicated Food storage areas should be clean at all times . Review of facility policy titled STORAGE & INVENTORY dated [DATE] indicated It is the policy of this facility to store all dining services supplies in clean, appropriate containers at the proper temperature and in location and manner prescribed by the law . Procedures .6. Date then store on shelves of appropriate height and in the correct manner, all goods in original container or Department of Health approved containers .10 .Date all cases .12. Check all foods in the refrigerator daily to make sure they are appropriately covered. All foods and foods not in original containers must be COVERED, LABELED and DATED .15. Leftovers shall be tightly covered, stored appropriately, and clearly labeled and dated .