STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555318	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rancho Bernardo Care Center	15720 Bernardo Center Drive San Diego, CA 92127

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- standard assessment to facilitate resident's care) related to hospice (medical care for residents expected to live six months or less) services were coded accurately for one of 3 sampled residents reviewed for hospice (Resident 212). As a result, Resident 212 did not reflect their current health status, which may lead to unmet hospice care needs. Findings: Resident 212 was admitted to the facility on [DATE] with diagnoses that included Dementia (memory problem) per the Admission Record. A review of Resident 212's medical records was conducted. Per the MDS assessment, dated 8/16/24, Section O Special Treatments, Procedure, and Programs, Resident 212 was not coded under hospice care. A review of Resident 212 Hospice Binder: Resident 212 received hospice care and service since 9/6/23, and there was no evidence that hospice services were discontinued. Per the November 2024 Order Summary, Resident 212 did not have hospice orders. On 11/7/24 at 8:04 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 212 was on hospice services since 9/6/23. LN 1 further stated she made a mistake and clicked the discontinued order in the physician order on 4/26/24. LN 1 stated Resident 212 was on hospice and remained under hospice care. On 11/7/24 at 10:25 A.M., an interview was conducted with the MDS 1. MDS 1 stated she did the MDS assessment on 8/16/24, and she did not see a physician order for hospice. MDS 1 stated she coded Resident 212 as not receiving hospice care. MDS 1 further stated Resident 212 should have been coded under hospice care. On 11/7/24 at 11:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 212 was receiving hospice care and the facility has a list of resident's name under hospice care. The DON further stated Resident 212 should have a physician order for hospice care, and MDS should have been coded for hospice accurately. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy and procedure, dated 12/19/22, titled MDS 3.0 Completion, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . Per the facility's policy and procedure, dated 12/19/22, titled Documentation in Medical Record, .Document shall be accurate, relevant, and complete .

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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** 46980 Based on interview and record review, the facility failed to create person-centered care plans (a document that outlines the care and support a patient will receive) regarding non-pharmacological interventions (a healthcare treatment that doesn't involve medication) for three of 35 sampled residents (Residents 240, 290 and 440). This failure had the potential to decrease the types of supportive interventions these residents received while at the facility. Findings: Resident 240 was admitted to the facility on [DATE] with diagnoses that included depression (a serious mental health condition that causes a persistent low mood). Resident 290 was admitted to the facility on [DATE] with diagnoses that included depression. Resident 440 was admitted to the facility on [DATE] with diagnoses that included depression. On 11/6/24 at 1:44 P.M., an interview and concurrent record review were conducted with the Licensed Nurse (LN) 4 and the Assistant Director of Nursing (ADON) who stated Resident 240 was receiving two antidepressant medications for treatment of depression, Resident 290 was receiving one antidepressant medication for treatment of depression and Resident 440 was receiving three medications for depression. LN 4 and the ADON stated Residents 240, 290 and 440's care plans did not include individualized and non-pharmacological interventions. The ADON further stated there were no orders from the providers, and no documentation in the Medication Administration and Treatment Records (a daily documentation record used by a licensed nurse to document medication and treatment given). A review of the facility policy titled Comprehensive Care Plans revised on 12/19/22 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes . resident specific interventions . A review of the facility policy titled Use of Psychotropic Medication revised on 12/19/22 indicated, Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270 Based on observations, interview and record review, the facility failed to flush a gastronomy tube (GT- artificial external opening in the stomach for nutritional support) between each medication administered with water for one resident of four sampled residents reviewed for GT (Resident 1). This failure had the potential for Resident 1's GT to malfunction. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing) and a gastrostomy tube, per the resident's Admission Record. On 11/6/24 at 8:43 A.M., a concurrent observation and interview of a medication administration was conducted with Licensed Nurse (LN) 11. LN 11 administered the following medications via GT: -Polyethylene glycol (constipation prevention) 17 grams (gm) mixed with 240 milliliters (mLs) of water -Multivitamin with minerals (supplement) mixed with 15 mLs of water -Cetirizine (itchiness relief) 10 milligrams (mg) mixed with 15 mLs of water -Calcium carbonate (supplement) 1,250 mg mixed with 30 mLs of water -Gabapentin (pain management) 300 mg mixed with 15 mLs of water During administration of each medications via Resident 1's GT, LN 11 did not flush the GT between each medication with water. On 11/6/24 at 9:10 A.M., LN 11 confirmed it was a nursing standard of practice to flush a resident's GT between each medication that was administered. A record review of Resident 1's medication orders was conducted. On 3/22/24, the physician ordered Enteral (method of food or medication administration) Feed Order- every shift Enteral Feeding: flush enteral tube with 15-30 mLs of water before and after medication administration and 5 mLs water between each medication. On 11/07/24 at 11:44 A.M., the Director of Nursing (DON) stated that a resident's GT needs to be flushed with water between each medication during medication administration. The facility policy titled, Medication Administration via Enteral Tube, dated 12/19/22, indicated nurses must . Flush enteral tube with at least 15 mLs of water prior to administrating medication .and .Flush tube again with at least 15 mLs water .

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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** 47466 Based on observation, interview and record review, the facility failed to ensure behavior monitoring was in placed for a psychotropic (drugs that affect a person's mental state) medication in one of five reviewed for unnecessary medications (Resident 279). This failure had the potential for Resident 279 to continuously received the medication without proper monitoring and possibly affect Resident 279's health condition and or decline. Findings: A record review of the facility's Admission Record indicated Resident 279 was admitted to the facility on [DATE] with diagnoses that included Depression (a group of condition associated with the elevation or lowering of a person's mood) and Essential Hypertension (elevated blood pressure). An observation on 11/5/24 at 9:30 A.M., in Resident 279's room was conducted. Resident 279 was lying in bed, asleep . An observation on 11/6/24 at 2 P.M., in resident 279's room was conducted. Resident 279 was asleep with no behaviors. A record review of Resident 279's Minimum Data Set (MDS- a federally mandated assessment tool) dated 10/1/24 indicated a brief interview for mental status (BIMS) a score of 11 which indicated Resident 279's cognition was moderately impaired. A record review of resident 279's medication review report dated 10/1/24 to 10/31/24 indicated the following: .Mirtazapine (an antidepressant medication) oral tablet 7.5 milligram (mg-unit of measurement), 1 tablet via GT at bedtime for depression . An interview on 11/6/24 at 11:12 A.M., with Licensed Nurse (LN) 2 was conducted. LN 2 stated Resident 279 had no behavior monitoring for his mirtazapine usage. LN 2 stated she would call Resident 279's medical doctor to have the medication discontinued. LN 2 stated she did not know why Resident 279 had the medication in the first place since he was on tube feedings. A record review of the progress notes titled, type of assessment: psychotropic medication -present on admitted d 9/27/24 at 10:38 A.M., indicated mirtazapine was used for insomnia, not sleeping; behavior observed; sad tearful. A record review of Resident 279's care plan indicated Resident 279 was on antidepressant medication related to depression with no behaviors documented. An interview on 11/7/24 at 10:57 A.M. with the Director of Nursing (DON) was conducted. The DON stated it was important to have the specific behavior monitoring to know if the medication was effective. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy titled, Use of Psychotropic Medication, dated 12/19/22, indicated .and the medication is beneficial to the resident as demonstrated by monitoring and documentation . 11 .d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on observation, interview and record review, the facility failed to ensure medications were not left unattended in one of six residents observed for medication storage (Resident 18). This failure had the potential to affect residents' safety and may lead to drug diversion. Findings: A record review of the facility's Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included Dementia (a progressive state of decline in mental abilities) and Heart Failure. An observation on 11/4/24 at 9:25 A.M., in Resident 18's room was conducted. Resident 18 had two medications, one round pill and one yellow pill inside a small clear cup sitting on Resident 18's bedside table. Resident 18 stated, the nurse left the medications there for her to take after breakfast. Resident 18 stated she did not know what the medications were and what for. An interview on 11/6/24 at 10:10 A.M., with Licensed Nurse (LN) 2 was conducted. LN 2 stated it was important not to leave medications unattended in a resident's room for their safety. An interview on 11/6/24 at 12:01 P.M., with the Director of Nursing (DON) was conducted. The DON stated medications were not to be left unattended anywhere in the facility including resident's rooms for their safety. A review of the facility's policy dated 12/19/22 titled, Medication Storage indicated Policy Explanation and Compliance Guidelines .1 .c. during a medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area / cart .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on observation, interview and record review, the facility failed to ensure a clinical record was complete for one of 35 residents reviewed for medical record accuracy (Resident 153) when a physician's order for rolled washcloth was not monitored. This failure had the potential for Resident 153 to not have the adequate care and to not communicate Resident 153's care needs amongst healthcare providers. Findings: A record review of Resident 153's Admission Record indicated Resident 153 was admitted to the facility on [DATE] with diagnoses that included Muscle Weakness and Contracture (a stiffening /shortening at any joint, that reduces the joint's range of motion) of muscle, upper arm. A joint observation and interview on 11/4/24 at 8:50 A.M., with Resident 153 was conducted. Resident 153 had rolled washcloths on both her hands. Resident 153 stated she had the contractures for years now due to her arthritis (pain and stiffness of joints). A record review of Resident 153's Minimum Data Set (MDS- a federally mandated assessment tool) dated 8/14/24, Section GG - Functional Abilities and Goals indicated Resident 153's had impairments on both upper extremities. An interview on 11/6/24 at 8:37 A.M., with Certified Nursing Assistant (CNA) 4 was conducted. CNA 4 stated, the nurses did the rolled washcloths on both her hands but was not sure when and how often the washcloths were removed. An interview on 11/6/24 at 3:00 P.M., with Licensed Nurse (LN) LN 2 was conducted. LN 2 stated, nursing placed the rolled washcloths on both Resident 153's hands daily and checked them every shift for placement but it was not documented anywhere in Resident 153's medical record. LN 2 stated if it was not documented, it was not done. LN 2 stated it was important to have the rolled washcloths on both Resident 153's hands to prevent further contractures and to maintain Resident 153's skin integrity. An interview on 11/6/24 at 3:30 P.M., with LN 3 was conducted. LN 3 stated nursing should follow the doctor's orders either medication or treatment and document. LN 3 stated the nurses placed the washcloth and checked placement every two hours to check for skin breakdowns and or integrity. A record review of Resident 153's medication review report dated 10/1/24 to 10/31/24 indicated Resident 153 had the order for OK to use rolled washcloth to contractures on bilateral hands and fingers. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/7/24 at 3:00 P.M., with the Director of Nursing (DON) was conducted. The DON stated we did not have the monitoring of the rolled washcloths documented anywhere in Resident 153's medical record. The DON stated it was important to document to ensure treatment was effective or not. The DON further stated, also to prevent further contractures and ensure Resident 153's skin integrity preventing skin breakdowns. A record review of the facility's policy titled , Consulting Physician/Practitioner's orders dated 12/19/22 indicated .3d. follow facility procedures for verbal or telephone orders including .transcribing to medication or treatment administration record .