STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Pacific Regent	3884 Nobel Drive San Diego, CA 92122

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** Based on interview and record review the facility failed to ensure the baseline care plan included person-centered care during mealtimes for one of fourteen residents (Resident 86) within 48 hours of the resident's admission. This failure to develop the baseline care plan within 48 hours of admission for mealtime assistance resulted in the resident calling to request mealtime set ups multiple times a day continuously since admission. Findings:A review of the facility's admission Record indicated Resident 86 was readmitted to the facility on [DATE] with diagnosis including Pigmentary Retinal Dystrophy (an inherited eye disorder that causes loss of sight). On 8/3/25 at 9:10 A.M., an interview was conducted with Resident 86. Resident 86 stated that she was legally blind and needed help with meal tray set up. Resident 86 stated she needed staff to identify the food items and the location of the food on her plate. Resident 86 then stated that she would have to wait to eat and then call to remind the staff that she needed help with her tray set up almost every meal. Resident 86 stated she should not have to remind the staff of her needs every day. On 8/6/25 at 11:20 A.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated she was not aware that Resident 86 was legally blind. CNA 1 stated it was her first time to take care of Resident 86, and she was not informed of Resident 86's blindness. On 8/6/25 at 11:31A.M., an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated he knew Resident 86 was blind and that she needed help with mealtime set up. LN1 stated mealtime set up should have been included in Resident 86's care plan and help should have been provided. On 8/6/25 at 1:55 P.M., a concurrent interview and record review with LN3 was conducted. LN 3 reviewed Resident 86's written care plans and stated there was no intervention to provide set up assistance during mealtimes. LN 3 stated mealtime assistance should have been a part of Resident 86's baseline care plan. On 8/6/25 at 2:29 P.M., a concurrent interview and record review with the Director of Nursing (DON) was conducted. The DON acknowledged that there was no care plan developed for Resident 86's mealtime assistance. The DON stated the purpose of baseline care plan was to identify basic needs of a resident at the time of admission to the facility. The DON stated that a care plan for meal tray set up should have been developed. A review of the facility's undated policy titled Comprehensive Person-Centered Care Planning, indicated, .1. Within 72 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.On 8/14/25 at 12:29 P.M., a telephone interview was conducted with the Assistant Director of Nursing (ADON). The ADON was informed that the facility's policy titled Comprehensive Person-Centered Care Planning did not follow the Federal Regulation for Baseline Care Plan development within 48 hours. The ADON stated the facility's policy should have been in alignment with Federal regulations.

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
	555739	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Pacific Regent	3884 Nobel Drive San Diego, CA 92122

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 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** Based on interview and record review, the facility failed to provide proper pharmaceutical services when the Medication Administration Record (MAR) and Controlled Medication Count Sheet (CMCS) did not reconcile for two randomly selected residents (Resident 91 and 61). This failure had the potential to place Resident 91 and Resident 61 at risk for inaccurate pain medication administration and/or diversion (illegal distribution or abuse of prescription drugs) of controlled medications (medications that the use and possession of are controlled by the federal government). Findings:1. A review of Resident 91's admission record indicated the resident was admitted to the facility on [DATE] for the diagnosis including post-surgery care for joint replacement surgery and osteoarthritis (a condition where the cartilage in the joints wears down over time and causes pain). A review of Resident 91's physician order dated 7/21/25 indicated: Oxycodone HCL oral tablet (a type of controlled medication) 5 MG (milligrams). Give one tablet by mouth every 4 hours as needed for moderate pain level 4-6 (pain scale that utilizes numbers used to evaluate a person's perceived pain level) and give 2 tablets by mouth every 4 hours as needed for severe pain level 7-10. A review of Resident 91's MAR and CMCS indicated: A dose of the resident's Oxycodone HCL 5 MG had been removed from the locked supply on 7/31/25. Resident 91's MAR for Oxycodone HCL 5 MG had blank entry on 7/31/25 and it could not be determined if the medication had been given to the resident.2. A review of Resident 61's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including post-surgery care.A review of Resident 61's physician order dated 5/28/25, indicated: Hydrocodone-Acetaminophen Oral Tablet (a controlled medication) 10-325 MG. Give 1 tablet by mouth every 4 hours as needed for severe pain (level 7-10). On 8/5/25 at 10:50 A.M., an interview was conducted with Licensed Nurse (LN) 4. LN 4 stated the process of controlled medication administration was to verify resident's pain level, remove the medication from its locked storage, compare the physician's order to the MAR and CMCS, administer the medication, and document on the MAR and CMCS. LN 4 stated it was important that the MAR and CMCS reconciled to prevent diversion of the medications. On 8/6/25 at 9:32 A.M. , a concurrent interview and record review was conducted with the Director of Nursing (DON) for Resident 61's MAR and CMCS for Hydrocodone-Acetaminophen oral tablet.The DON reviewed Resident 61's MAR and CMCS for Hydrocodone-Acetaminophen 10-325 MG on the following dates:- 8/5/25 at 1:23 A.M. - 8/1/25 at 1:59 A.M.- 7/27/25 at 9:42 P.M.- 7/24/25 at 6:20 P.M.- 7/23/25 at 12:30 P.M.- 7/18/25 at 5:17 A.M.- 7/15/25 at 11:29 A.M.- 7/15/25 at 12:03 A.M.- 7/11/25 at 4:45 A.M.- 7/10/25 at 5:26 P.M.- 7/9/25 at 10:30 P. M.- 7/23/25 at 9:41 A.M. The DON stated the MAR and CMCS did not reconcile. The DON then reviewed Resident 91's MAR and CMCS for oxycodone 5 MG and stated that they did not reconcile on 7/31/25.The DON stated the MAR and CMCS should reconcile because they were documentation of controlled medications, nursing communication, and accountability of the staff giving controlled medications. A review of the facility's undated policy titled Controlled Medications - Storage and Reconciliation indicated, .6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration. Amount administered. Signature of the nurse administering the dose, completed after the medication is actually administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Pacific Regent	3884 Nobel Drive San Diego, CA 92122

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Pacific Regent	3884 Nobel Drive San Diego, CA 92122

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. On the clean dish rack there was a cracked 7.5 quart plastic cambro container, two serving dishes that had food particles stuck on them and four wet mixing bowls stacked on a shelf.2. Refrigerated food items had a white, fuzzy substance growing on them and were stored alongside unspoiled food products. Two refrigerated peeled and cut cucumbers were wrapped in plastic and not labeled or dated.3. A large cambro container in the warming oven had a yellow, clear, liquid substance in it that was labeled as olives. Food particles and crumbs were in the drawers and on the shelves of the prep cart. A spatula was covered with a slimy, greasy coating. There were grease smudges on the back of the plate dispenser. 4. The cook (CK) took temperatures of the food on the steam table without visualizing where the temperature probe was placed. 5. The temperature of soup was not taken prior to placing the soup on the meal tray for service.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 8/3/25 at 7:30 A.M., an observation and interview was conducted with the Dietary Supervisor (DS) of the clean dish storage rack. The DS stated these dishes were clean and ready for service. Four mixing bowls were stacked on top of each other, and water was in the bottom of each bowl. Two serving dishes had food particles on them. A 7.5-quart plastic cambro container was cracked. The DS removed the four wet mixing bowls, the serving dishes with food particles on them and the cracked cambro container from the clean storage rack. 2. On 8/3/25 at 7:43 A.M., an observation of the produce walk-in refrigerator and an interview was conducted with the DS. There was spoiled produce stored with non-spoiled produce: Two cantaloupes in a box that were brown, soft and indentable to touch. The DS stated the cantaloupes should be thrown away. One plastic container of blueberries had a fuzzy white substance growing on multiple blueberries. The DS removed the container immediately and stated he would throw it away. Multiple soft apples, brown in color and indentable to touch were found in a box. The DS removed the apples immediately and stated he would throw them away. Half of a box of yellow squash were brownish in color, had slimy soft spots and were squishy to touch. Approximately 30 yellow squashes had visible fuzzy, white substance growing on them. The DS stated he would throw the entire box away. Two refrigerated, peeled, and cut cucumbers were wrapped in plastic and not labeled or dated.3. On 8/3/25 at 8:05 A.M., an observation and interview of the food prep area was conducted with the DS. There was a plastic container in the warming oven that had a clear, yellow liquid substance in it that was labeled as olives. The DS stated it was melted margarine. The utensil prep cart had food particles and crumbs in the drawers and on the shelves. A spatula was covered with a slimy, greasy coating. There were grease smudges on the back of the plate dispenser. 4. On 8/4/25 at 11:53 A.M., an observation of the tray line was conducted. CK placed foil covered containers onto the steam table. CK put the thermometer probe through the top of multiple foil covered containers to take to the temperature reading of the food. The thermometer probe was not visualized to be touching the food, and the probe could be heard hitting the bottom of the metal food container. On 8/4/25 at 12:04 P.M., an interview was conducted with the DS. The DS stated the thermometer probe should have been visualized touching the food when taking the temperature. The DS stated this would ensure the temperature of the food was taken appropriately. 5. On 8/4/25 at 12:27 P.M., an observation and interview was conducted with the DS. The DS handed a bowl of soup to the dietary aide. The dietary aide placed the soup on a meal tray in the food cart for service. The food temperature log was requested for review. The log entry for the soup was blank. The DS stated the temperature of the soup was not taken before being served and it should have been. On 8/5/25 at 8:51 A.M., an interview was conducted with the DS. The DS stated cracked cambro containers should have been thrown away due to the potential for contamination. The DS stated spoiled food should not have been stored with non-spoiled food. The DS stated the refrigerated food should have been checked daily to ensure the quality of the food product. The DS stated that all food products that had been used should have been wrapped in plastic, labeled and dated. The DS stated that prep carts should have been clean with no food particles in the drawers and the cart should have been free from grease smudges. On 8/5/25 at 9 A.M., an interview was conducted with the Registered Dietician (RD). The RD stated she was informed that there was spoiled cantaloupes, white fuzzy growth on the blueberries, brown apples and yellow squash with fuzzy, white growth on them and these items were mixed with unspoiled produce. The RD stated the food should have been checked and there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555739	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Pacific Regent	3884 Nobel Drive San Diego, CA 92122

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 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** Based on observation, interview, and record review, the facility failed to follow appropriate infection prevention and control practices related to hand hygiene (washing hands with soap and water or using alcohol-based hand sanitizer) during wound care for one resident (Resident 51). As a result of this deficient practice, Resident 51 was at an increased risk of infection. Findings: A review of Resident 51's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain) and hemiplegia (paralysis or severe weakness on one side of the body).A review of Resident 51's physician order for wound treatment dated 7/29/25, indicated Resident 51 had an unstageable pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on the coccyx (tailbone) area. On 8/6/25 at 10:24 A.M., an observation of wound treatment for Resident 51 was conducted with Licensed Nurse (LN) 2 and Certified Nursing Assistant (CNA) 2. LN 2 and CNA 2 were observed wearing Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) including gloves. LN 2 and CNA 2 stated they were cleaning and changing the resident's soiled brief before starting Resident 51's wound care. Some stool was observed on Resident 51's bilateral buttock. After cleaning Resident 51, CNA 2 stepped out to grab some supplies. When CNA 2 came back with the supplies, LN 2 stepped out to wash her hands. LN 2 then came back, donned new gloves, and proceeded with wound treatment while CNA 2 supported the resident who was turned to her left side. After informing Resident 51 that LN 2 was starting the wound care, LN 2 removed the foam dressing that covered Resident 51's pressure ulcer. The wound was open, clean, and located slightly below the coccyx and slightly right to the midline. The wound was approximately 2.5 cm (centimeters) by 4 cm in measurement. LN 2 used dressings soaked with wound cleanser to gently pat on the wound. LN 2 removed her gloves and put on a new pair without performing hand hygiene.LN 2 stated the wound was a pressure ulcer with hypergranulation (healthy tissue that normally forms during wound healing grows too much and rises above the level of the surrounding skin), with slough (a type of dead tissue that can prevent healing) about 5 to 10% at 3 o'clock to 5 o'clock, and with possible undermining (the destruction of tissue extending under the skin) to 12 o'clock. LN 2 pat-dried the wound with dry dressings. LN 2 removed her gloves and put on a new pair without performing hand hygiene. LN 2 applied a medicated ointment to the wound bed.LN 2 removed her gloves and put on a new pair without performing hand hygiene.LN 2 applied a medicated power to the wound bed.LN 2 removed her gloves and put on a new pair without performing hand hygiene.LN 2 applied a special dressing that promoted wound healing.LN 2 removed her gloves and put on a new pair without performing hand hygiene.LN 2 covered the wound with a foam dressing.On 8/6/25 at 10:43 A.M., an interview with LN 2 was conducted. The wound treatment observation for Resident 51 was discussed with LN 2. LN 2 stated she should have done hand hygiene between glove changes.On 8/6/25 at 1:55 P.M., an interview was conducted with the Infection Preventionist (IP). The IP was asked about the facility's hand hygiene policy. The IP stated the staff were expected to perform hand hygiene when donning a new gloves. On 8/6/25 at 2:29 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that performing hand hygiene during wound care was expected and necessary before putting on a new pair of gloves to decrease the risk of infections. A review of the facility's undated policy and procedure titled Hand Hygiene, indicated, .2. Use an alcohol-based hand rub.for the following situations: .b. Before and after direct contact with residents; c. Before preparing or handling medications; .g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; .j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; .m. After removing gloves; .r. After removing and disposing of personal protective equipment.