STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555326	A. BUILDING _____ B. WING _____	03/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARMEL MOUNTAIN REHABILITATION & HEALTHCARE CENTER	11895 AVENUE OF INDUSTRY SAN DIEGO, CA 92128

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all exterior access doors to the facility were secured at night. This failure had the potential to create an unsafe environment for residents and staff. Findings: An unannounced visit was made to the facility on [DATE] at 6 A.M., to investigate a complaint that the facility's back gate and back door were left open 24 hours. The facility was observed to have a back parking lot and a large courtyard, surrounded by wrought iron fencing on the north side of the building. There were two gates in the fencing that were open. On 3/6/20 at 6:04 A.M., the courtyard was entered through an open gate at the north-east side of the building. The facility was entered from an unlocked door at the north-east side of the facility into a small physical therapy (PT) gym. Through the PT gym door was a short hallway to an alarmed emergency exit at the east end, and to the hallway of station one where resident rooms were, towards the west. On 3/6/20 at 6:06 A.M., the facility was exited through the small PT gym into the back courtyard. Another entrance to the facility was accessed through the back courtyard at the north side of the building. This unlocked door led into a hallway at station one resident rooms, to the left (east), and at station two resident rooms, to the right (west). Standing in the hallways, a housekeeper and cart was observed halfway down the east hallway, and staff were observed by the nursing station at the end of the west hallway, none of the staff acknowledged or approached this surveyor upon entrance to the facility. On 3/6/20 at 6:10 A.M., the facility was exited back into the courtyard from the north back door, and re-entered into station one at 6:12 A.M. via the north-east door and the small PT gym. During an interview with licensed nurse (LN) 1 on 3/6/20 at 6:13 A.M., LN 1 stated she was in charge of station one on the night shift (11 P.M. until 7:30 A.M.). LN 1 stated she made rounds on the unit at the beginning of the shift and a few more times through-out the night. LN 1 stated during her rounds she checked on all residents on her unit, and checked to see if the alarmed doors were closed. During a concurrent observation and interview with the director of staff development (DSD) on 3/6/20 at 6:16 A.M., the door from the hallway to the small PT gym at the north-east side of station one was locked and the DSD was unable to enter. The DSD stated nursing did not have the key to the small PT gym, and that PT was responsible for locking the outside entrance to that room. During an interview with the DSD on 3/6/20 at 6:24 A.M., the DSD stated they had recently started locking the north door from the courtyard at night. The DSD stated prior to 3/5/20 the north door was always opened so employees or visitors could access the facility from the back parking lot. During a concurrent observation and interview with the DSD on 3/6/20 at 6:26 A.M., the employee area was observed at the west side of the building and exited through a Service Entrance next to the trash dumpster's and an alleyway that led to the back parking lot. The DSD stated this service entrance was where employees entered the facility and was always open. During an interview with certified nursing assistant (CNA) 2 on 3/6/20 at 6:43 A.M., CNA 2 stated when he started his shift at 11 P.M., he entered the facility through the front door. CNA 2 stated the facility front door was locked at night and he would ring the door bell and staff would come open the door. CNA 2 stated he accessed the facility the same way during his break, which was usually between 2 and 2:30 A.M. During an interview with CNA 3 on 3/6/20 at 6:49 A.M., CNA 3 stated when she came to work at 11 P.M., she entered the facility using the side door by the dumpster's (service entrance). CNA 3 stated when she took her break at 3 A.M., she again used the side door, and the door was always unlocked. During an interview with LN 4 on 3/6/20 at 6:52 A.M., LN 4 stated at 11 P.M., when she entered the facility from the side door by the dumpster's. LN 4 stated, The door by the dumpster's are always unlocked. On 3/6/20, during a tour of the facility with the day shift nursing supervisor (LN 5) and the maintenance director (maint dir), all entry doors to the facility were observed. All entry doors to the facility were observed and the findings were: At 7:22 A.M., the facility was entered through the unlocked north-east door to the small PT gym and into the hallway to station one. LN 5 stated someone could come from the outside undetected into the unit via that north-east PT gym door. At 7:26 A.M., LN 5 stated the back door on the north side of the facility was not locked at night because employees and visitors entered through the back courtyard if they parked in the back parking lot. The fenced back courtyard gates were observed to have key pad locks and were not closed or locked. The maint dir stated the gates were not locked, Because the employees don't like to walk around to the front. At 7:31 A.M., both LN 5 and the maint dir stated the side door by the dumpster's and the employee lounge was how the night shift got into the facility and was always unlocked. During an interview with the Director of Rehabilitation (DOR) on 3/6/20 at 8:31 A.M., the DOR stated the therapy staff closed the back PT gym door when they were done for the day. The DOR stated the door from the gym to the unit locked on its own when the door was closed. The DOR stated it was the nurses that locked the outside door with a key. During an interview with the Occupational Therapist (OT- therapist to help learn or relearn activities of daily living) on 3/6/20 at 8:44 A.M., the OT stated when the therapist working in the small gym was done for the day they just closed the door from the gym to the unit. The OT stated nursing had the keys to lock the outside small gym door. During an interview with the administrator (admin) on 3/6/20 at 8:53 A.M., the admin stated nursing on the night shift did rounds and locked the exterior back doors, and the doors were expected to remain closed at night. The admin stated the staff entrance on the side of the facility was supposed to be locked at night, except during the staff breaks when it remains open. According to a review of the facility's policy, titled Security of the Facility, dated 5/17, .Exits: .2. The service area and main entrance area that is used by visitors, staff and service trucks, etc. for deliveries must be established which doors will be used for these purposes. A. Once this is established the doors that are not main entrances and are used for emergency egress, alarms to these areas for entrance and exit, any unauthorized person entering or exiting will automatically activate the alarm and notify the staff that there could be a potential problem .

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