STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055067	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Vista Healthcare Center	201 N Fig Street Escondido, CA 92025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure home health services were confirmed prior to discharge for three of three sampled residents (1, 2, 3).As a result, the residents were at risk of having unmet care needs, discharge summaries for Resident 1 and Resident 2 were inaccurate, and Resident 1 had to go to a General Acute Care Hospital (GACH) to have his post-discharge needs met.Findings:1. Per the facility's admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses to include peritoneal abscess (infection in the abdomen) and change or removal of surgical wound dressing. Resident 1 discharged to home on [DATE].Per the facility's Orders, there was an order dated 12/26/25 at 5:07 P.M., for Resident 1 to discharge from the facility on 12/26/25 with Home Health services for Registered Nurse visits, wound care, and Physical Therapy visits.Per the facility's Progress Notes, dated 12/26/25 at 6:13 P.M., At around (6 P.M.). patient is being discharged to home.Wound VAC (a sealed wound dressing that uses a vacuum pump to maintain suction on the wound to remove fluid and promote healing) present to midline abdominal incision (a surgical incision to the stomach).Per the facility's Discharge Summary and Post-Discharge Plan of Care, dated 12/26/25 at 4:48 P.M., We have arranged the following community resources to assist your transition to your new living environment.Name of Agency: [Home Health Agency (HHA) 1]Per the facility's Confirmation Report, dated 12/26/25, a referral was faxed to HHA 1 on 12/26/25 at 6:29 P.M., (about 29 minutes after Resident 1 discharged from the facility.) A handwritten note was on the fax stating that HHA 1 did not accept the referral.Per the facility's Progress Notes, dated 1/8/26, there were no progress notes regarding Resident 1's discharge planning prior to the Social Services Assistant (SSA)'s notes on 12/30/25 (four days after discharge).Per the GACH's admission History and Physical note, dated 1/1/26, Resident 1 was admitted to the GACH on 12/30/25 (four days after discharge) and Resident 1 stated that had a wound VAC placed and was told that home health was going to come to his house 3 times a week to help with he wound VAC.He went home to his family on Friday and since then no nurse has arrived, he has not known how to take care of his wound VACOn 1/14/26 at 4:05 P.M., a telephone interview was conducted with the Social Services Assistant (SSA). The SSA stated, on 12/30/25 (four days after discharge) the SSS asked her to help send referrals to HHAs.On 1/15/26 at 2:33 P.M., an interview was conducted with the Administrator and Director of Nursing In Training (DONIT). The Administrator stated, the process of sending out referrals to HHAs should have started as soon as the facility became aware of a resident's discharge date . The DONIT stated, the HHAs should have been confirmed prior to the residents' discharges.2. Per the facility's admission Record, Resident 2 was admitted to the facility on [DATE] with diagnoses to include difficulty walking and pneumocystosis (a fungal infection in the lungs). Resident 2 discharged to home on [DATE].Per the facility's Orders, there was an order on 12/29/25 at 9 A.M. for Resident 2 to discharge to home with Home Health services for Registered Nurse visits, and Physical Therapy visits.Per the facility's Discharge (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note, dated 12/26/25 at 10:54 A.M., Home health referral sent to [HHA 2].pending review and acceptance.Per the facility's Discharge Summary and Post-Discharge Plan of Care, dated 12/29/25 at 9:03 A.M., We have arranged the following community resources to assist your transition to your new living environment.Name of Agency: [HHA 2]Per the facility's Progress Note, dated 12/29/25 at 11:16 A.M., Resident 2 was discharged to home.Per the facility's Discharge Planning Note, dated 12/29/25 at 3:09 P.M., (more than three hours after discharge) HHA 2 did not accept the referral.Per the facility's Discharge Planning Note, dated 12/30/25 at 11:21 A.M., (more than 24 hours after discharge) the SSA documented that HHA 3 confirmed they would accept the referral for Resident 2.On 1/14/26 at 4:05 P.M., a telephone interview was conducted with the SSA. The SSA stated, the day HHA 3 confirmed that they would accept Resident 2's referral was when she documented it on 12/30/25 (the day after discharge).On 1/15/26 at 2:33 P.M., an interview was conducted with the Administrator and DONIT. The admin stated, the process of sending out referrals to HHAs should have started as soon as the facility became aware of a resident's discharge date . The DONIT stated, the HHAs should have been confirmed prior to the residents' discharges.3. Per the facility's admission record, Resident 3 was admitted to the facility on [DATE] with diagnoses to include acute cholecystitis (gallbladder inflammation causing abdominal distress), and artificial openings of digestive tract. Resident 3 was discharged to home on [DATE].Per the facility's Discharge summary, dated [DATE] at 12:07 P.M., Home Health services had been arranged with HHA 4.Per the facility's Discharge Planning Note, dated 12/24/25 at 12:12 P.M., a home health referral was made with HHA 4. Pending review and acceptance.On 1/15/26 at 2:33 P.M., an interview was conducted with the Administrator and DONIT. The admin stated, the process of sending out referrals to HHAs should have started as soon as the facility became aware of a resident's discharge date . The DONIT stated, the HHAs should have been confirmed prior to the residents' discharges.On 1/16/26 at 10:28 A.M., a telephone interview was conducted with the SSS. The SSS stated, she sent Resident 3's referral to HHA 4, but she did not hear back from HHA 4 on whether they accepted Resident 3 or not, and she did not have a chance to follow up on the referral before or after Resident 3's discharge.Per the facility's policy, titled Admission, Transfer and Discharge Rights, Subject: Discharge Planning Process, revised 5/2025, The discharge process should effectively transition them (residents) to post-discharge care.1. The Facility's discharge planning process shall.b. Ensure that the discharge needs of each resident are identified on admission, and that a discharge plan for each resident is developed and implemented in a timely manner.