

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Palomar Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to maintain a safe, clean, comfortable and homelike environment for seven of 21 sampled residents when it:1. Did not repair damaged phone jack boxes that were hanging from the walls and walls damaged from bed and furniture movement.2. Allowed night staff to enter and exit through an alarmed side gate and door during the night, waking residents near to that area.3. Placed a portable air conditioner in the hallway with 12 feet of 8-inch diameter (width) tubing connected to the residents' handrailing with large zip ties.This failure had the potential to increase accidents, disrupt needed sleep, and create an overall depressing atmosphere for the affected residents.Findings: 1. Review of the admission record for Resident 43 indicated she was admitted on [DATE] for diagnoses which included: Cerebral Infarction(a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue), Major Depressive Disorder(condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and Functional Quadriplegia (a condition in which a person is completely unable to move due to severe disability or frailty, but without any underlying physical injury or damage to the brain or spinal cord). Review of Minimum Data Set (MDS-A standardized assessment done in nursing homes) Section C-Cognitive (thinking) Patterns for Resident 43, dated 5/15/25, indicated Brief interview for Mental Status (BIMS) score of 14 indicating intact cognition (thinking processes). Review of admission Record for Resident 85 indicated he was admitted on [DATE] for diagnoses which included: Cerebral Infarction and Major Depressive Disorder. Review of MDS Section-C Cognitive Patterns for Resident 85, dated 3/20/25, indicated a BIMS score of 5 indicating severe cognitive impairment. Review of admission Record for Resident 8 indicated she was admitted on [DATE] for diagnoses which included: Late Syphilitic Neuropathy (a complication of the sexually transmitted infection, syphilis that affects the nervous system), Human Immunodeficiency Virus Disease (is a virus that attacks the body's immune system), Schizoaffective Disorder, Bipolar Type (a mental health condition). Review of MDS Section-C, Cognitive Patterns for Resident 8, indicated a BIMS score of 12 indicating moderate cognitive impairment. On 9/9/25 at 9:54 A.M., an observation of room [ROOM NUMBER]-A's wall was conducted. 15 A's entire phone jack box was pulled out of the wall and was still connected to the 15-B's phone wire. Approximately one and a half feet of phone wire connected the phone jack box to the wall, and about a foot of phone wire for bed 15-B stretched across the floor about an inch above the floor surface to the right side of 15-B's bed.On 9/9/25 10:05 A.M., an observation of room [ROOM NUMBER]-B and interview with Resident 43 was conducted. Resident 43 stated that 15-A's phone jack had been like that for a while. 15-B's wall was observed to be scraped and scratched with plaster and paint coming off wall in a two by four-foot area on left wall of her bed. Resident 43 stated the wall was depressing and not homelike.On 9/11/25 at 8:40 A.M., an observation of room [ROOM NUMBER]-A and interview with Resident 85 was conducted. The area behind the resident's bed was observed to be damaged in an approximate two by four-foot area by the side of bed with vertical scrapes and gouges of paint and drywall. Resident 85 stated he wanted the facility to fix the wall.On 9/11/25 at 8:45 A.M., an observation of (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] was conducted. 16-B's left wall had a one-by two-foot-long area by bedrail with large horizontal scrapes of brown paint exposing the drywall. 16-C's wall had two vertical scrapes about one inch wide by one-foot long on the right side of the bed and on left side of bed two by two-foot area with a damaged wall that had been painted over without fixing the wall. On 9/11/25 at 9:04 A.M., an interview with Resident 8 and observation of room [ROOM NUMBER]-B was conducted. Wall damage behind Resident 8's bed was observed in a two by four-feet area with the paint scraped down to drywall. Resident 8 stated the wall did not make her feel homelike and she would like it repaired. On 9/12/25 at 8:45 A.M., observation of room [ROOM NUMBER] was conducted. Broken plaster by 14-B's sliding glass door was observed to be about one foot long by one wide inch gap in the wall. On 9/12/25 8:56 A.M., an observation of room [ROOM NUMBER]-B was conducted. 11-B's phone jack box was ripped out of the wall and was resting on the floor, still connected to 11-A's phone wire. About one foot of phone wire was observed connected at one end to phone box jack, and the other end coming out of the wall. On 9/12/2025 at 8:57 A.M. an observation of room [ROOM NUMBER]-B and interview with Certified Nursing Assistant (CNA) 23 was conducted. CNA 23 confirmed that the phone jack box was pulled out of the wall and should be repaired. CNA 23 stated she would log the damage in the maintenance book and call the Environmental Service Director (ESD) to repair. CNA 23 stated that the wire could be tripping hazard and could cause accidents and, Was not homelike. On 9/12/25 at 9:05 A.M, an interview and tour of damaged rooms was conducted with the ESD. All the above observed damage of rooms 8, 11, 14, 15, 16, and 25 were observed. The ESD stated that he did not have scheduled room rounds, but did random room checks. The ESD stated he did not keep any logs other than maintenance log for when he repaired reported maintenance. The ESD stated that the dislodged phone jack boxes could be a tripping hazard, the damaged walls were not homelike, and the broken wall by sliding door could let in pests. The ESD stated that the residents' environment should be safe, clean comfortable and homelike. On 9/12/2025 at 2:34 P.M., a concurrent interview with the Administrator (ADM) and observation of a slideshow of the facility damage was conducted. The ADM stated that the facility should be homelike, safe and in good repair to make residents feel at home. Review of facility policy titled Physical Environment, Environmental Conditions, dated 3/2025 indicated, The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public through monthly environmental rounds. The following environmental conditions shall be included in environmental rounds: Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents; Facility hallways must be free of clutter. Equip corridors with firmly secured handrails on each side. 2. Review of admission Record indicated Resident 69 was admitted on [DATE] for diagnoses which included: Infection of Internal Right Hip Prosthesis (an artificial body part), Cerebral Infarction (a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue), Major Depressive Disorder (condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and Chronic Kidney Disease (a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood). Review of Minimum Data Set (MDS-A standardized assessment done in nursing homes) Section C-Cognitive (thinking) Patterns for Resident 69, dated 8/22/25, indicated Brief interview for Mental Status (BIMS) score of 15 indicating intact cognition (thinking processes). Review of Resident Council notes from 8/21/25 indicated Resident 69, Is wondering the time frame for the side gate to be fixed. Staff are entering the building through the side door by his room and at times the door is being slammed shut. Made [Resident 69] aware that we will be speaking to staff/visitors and requesting to please be mindful of the door when entering or exiting the building. Review of Admissions Record for Resident 79 indicated resident was admitted on [DATE] for diagnoses which included: Spastic Quadriplegic Cerebral Palsy(a type of palsy (the loss of the ability to move) that affects all four limbs (arms and legs), Muscle Weakness, and Neuromuscular Dysfunction of bladder (a condition where the nerves and muscles that control bladder function are impaired, leading to abnormal urinary control). Review of (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS Section C-Cognitive Patterns, dated 8/8/25, for Resident 79 indicated a BIMS score of 12 indicating moderate cognitive impairment. On 9/9/2025 at 9:15 A.M., during initial pooling, an interview with Resident 69 was conducted. Resident 69 stated he had trouble sleeping because the employee entrance was next to his room and heard staff coming and going all night long. Resident 69 stated it was hard to sleep because the employees let door slam. In addition, Resident 69 stated the facility recently installed a gate with a coded lock. Resident 69 stated the gate sets off an alarm if the code is put in wrong. Resident 69 stated that he slept less at the facility than in the hospital. Resident 69 stated since the gate was installed, they had been using the side door as main entrance for staff entrance/exit and ambulance drop off at night. On 9/11/2025 at 9:13 A.M., a follow-up interview with Resident 69 was conducted. Resident 69 stated, The alarm goes off when code is not entered right. Had a hard time sleeping last night. Staff opening gate starts during 2nd shift at 10 PM. at 2-3 A.M., night shift staff go out gate for lunch. No peace, because every three hours the alarm goes off. The alarm went off seven times between 5:30 and 6 A.M. this morning. in the past it was the side door but now it's the gate. Employees don't know how to work the code. On 9/11/2025 at 9:21 A.M. an interview with Resident 79, Resident 69's roommate, was conducted. Resident 79 stated that the alarm from the gate woke him up from sleep often. On 09/11/2025 9:26 A.M., an observation of side door and side gate by room [ROOM NUMBER] and interview with the Environmental Service Director (ESD) was conducted. The ESD stated, The door is locked all day and should be locked at night. Nurses station has key to the door. side door was broken about 3 weeks ago. The ESD stated that if the door is labelled as for Emergency Use Only, it should be used only for emergencies. The ESD tested the door alarm, and a loud harsh tone was emitted. The ESD stated that the sound was not homelike and could wake residents from sleep. The ESD stated that a coded gate outside of room [ROOM NUMBER] window was installed recently and that he taught the staff how to enter the code. The ESD tested the gate alarm and a harsh tone was emitted. The ESD stated that the sound was not homelike and could wake a resident from sleep. On 9/12/2025 at 2:34 P.M., a concurrent interview with the Administrator (ADM) and observation of pictures depicting the side gate and side emergency door next to Resident 69 and 79's room was conducted. The ADM stated that the facility should be homelike, safe, and in good repair to make residents feel at home. Review of facility policy titled Physical Environment, Environmental Conditions, dated 3/2025 indicated the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public through monthly environmental rounds. The following environmental conditions shall be included in environmental rounds: Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents, Facility hallways must be free of clutter. Equip corridors with firmly secured handrails on each side. On 9/11/2025 at 8:56 A.M., an observation of a portable air conditioner (AC) in hallway and interview with Environmental Service Director (ESD) was conducted. A newly installed portable AC was observed by rooms 31-32-33. The portable AC was plugged into a hallway outlet. The main AC unit was approximately two and half feet tall by two and half feet wide, by two and half feet deep, taking up approximately a quarter of the hallway. Approximately 12 feet of silver eight- inch diameter (width) tubes for portable AC were secured to patient hand railing with six large white zip ties that were over a foot long. A gap of five to six inches at the connection points on the railing were noted, where possible hand entrapment could occur. One zip tie close to the window was not cut and extended about a foot in the air. The ESD stated residents could get caught on zip ties while walking. The ESD stated the large tubes could obstruct residents who have trouble walking. The ESD stated that the whole portable AC setup did not look homelike. The ESD stated that hallways should be unobstructed to prevent accidents, and hallways should be homelike. On 9/12/2025 at 2:34 P.M., a concurrent interview with the Administrator (ADM) and observation of a slideshow of the portable hallway AC was conducted. The ADM stated that the facility should be homelike, safe and in good repair to make residents feel at home. Review of facility policy titled Physical Environment, Environmental Conditions, dated 3/2025 indicated The facility must provide a (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	safe, functional, sanitary, and comfortable environment for residents, staff, and the public through monthly environmental rounds. The following environmental conditions shall be included in environmental rounds: Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents, Facility hallways must be free of clutter. Equip corridors with firmly secured handrails on each side.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receiving antipsychotic (medication for mood, behavior, or thinking) medications were monitored for side effects (SE), including postural hypotension (a drop in blood pressure from standing after lying or sitting down), for two of five residents (Resident 42 and Resident 28) sampled. These deficient practices placed both residents (Resident 42 and Resident 28) at risk for undetected adverse (serious life-threatening SE) drug reactions, which could lead to dizziness, fainting, falls, or other serious complications. Cross-Reference F658 Findings: 1) A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included history of Major Depressive Disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest). On 9/10/2025 at 2:44 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 42 was on an antipsychotic (medication for mood stabilization) medication (Rexulti 2 mg [milligrams] one time a day) for depression. LN 1 stated Resident 42 was followed by a Psychiatrist (Psych) with Psych note on 9/8/25 that indicated, .This patient carries longstanding history of chronic Major Depressive Disorder [MDD] and reported that she was initiated on Rexulti approximately one year ago. She stated that Rexulti has provided effective therapeutic benefit, particularly in improving her mood stability, energy and overall functioning. She expressed a strong preference to continue this medication . On 9/11/2025 at 3:26 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 42's antipsychotic medication monitoring for SE included, .Sedation [sleepiness], Dry mouth, constipation, slurred vision, EPS [extrapyramidal symptoms-uncontrolled movements], Weight gain, edema, Postural Hypotension . LN 1 stated there was no documentation found in Resident 42's clinical chart to support that postural hypotension was being monitored. LN 1 stated Resident 42 could have a syncope (fainting) episode, feel dizzy, experience headaches and could sustain an injury from fall accidents due to adverse SE of the antipsychotic medication. On 9/12/2025 at 11:43 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated her expectations were for the LNs to be implementing the monitoring for Resident 42's side effect for postural hypotension with her antipsychotic medication use. DON 1 stated it was important that postural hypotension is monitored closely to prevent accidents such as falls. DON 1 further stated it was important for LNs to implement monitoring of SE that may be out of range findings to report to the physician and pharmacy for medication review and make recommendations that provide safety and professional standards of care for residents with antipsychotic medications. A review of the facility's policy and procedure titled, Care and Treatment Psychotropic Drug Use dated 6/2025, indicated .The Licensed Nurses shall review the classification of the drug, the appropriateness of the diagnosis, its indication/ behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician . 2. Per the facility's admission Record, Resident 28 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (a mental illness of unstable moods). (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's Medication Administration Record (MAR), dated 8/1/25 & 8/31/25 Resident 28 had an order for Lurasidone (an antipsychotic medication also used to treat bipolar disorder). The MAR included an order to monitor for side effects of Lurasidone, including postural hypotension (a drop in blood pressure when sitting up or standing up). The MAR also had an order to check his blood pressure every Sunday while lying down and while sitting. Resident 28's blood pressure while sitting was not documented for any of the Sunday's in the month. On 9/12/25 at 10:18 A.M., an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated, when they documented that they were checking Resident 28's blood pressure while lying and sitting, they should have entered both blood pressure readings in the MAR. LN 11 further stated, if the second blood pressure was not documented, then there was no evidence that it happened. On 9/12/25 at 10:24 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated, when he took Resident 28's lying and sitting blood pressure, he should have documented both readings in the MAR. On 9/12/25 at 2:05 P.M., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated, the LNs should have documented Resident 28's sitting blood pressure on the MAR to prove it was done. The facility did not have a policy on postural blood pressure monitoring.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for four of 21 sampled residents (30, 42, 11, 8) when:1. The facility did not accurately account and manage one of 21 sampled resident's personal medications from an outside pharmacy,2. The facility did not monitor side effects (SE) of psychotropics(medications to stabilize mood), and3. The facility did not document giving medication at the time of administration. As a result, the facility may not have been providing necessary services to residents.Cross reference F605, F755 Findings:1. Review of admission Record for Resident 30 indicated that resident was admitted on [DATE] for diagnoses which included: Joint replacement surgery, Muscle Weakness, Recurrent Dislocation (when the normal position of a joint or other part of the body is disturbed) of Left Hip, Malignant Neoplasm (an abnormal growth of cells that have the potential to invade and spread to other parts of the body) of Breast, Major Depressive Disorder(a serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). Review of Minimum Data Set (MDS-standardized assessment done in nursing homes) Section C-Cognitive (thinking) Patterns, dated 7/16/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition (thinking processes). On 9/9/25 at 8:53 A.M., during initial pooling, an interview with Resident 30 was conducted. Resident 30 stated she was supposed to be taking an oral chemotherapy(an medication for cancer) pill, Verzenio. Resident 30 stated that she believed she had three packages of seven pills each given to her by the hospital, and she was only able to take one package of seven at the facility. Resident 30 stated that she believed the facility lost two of the three packages. Review of physician orders dated 8/28/25, indicated Verzenio Oral Tablet 100 MG (milligram-unit of measure), Give 1 tablet by mouth two times a day for Breast Cancer. A record review of the Electronic Medication Administration Record (eMAR-an electronic record of medications given for a resident) Administration Notes for Resident 30 from 8/29/25 to 9/10/25 was conducted. Review indicated Verzenio was .Not available. on the following dates 9/5/25, 9/6/25, 9/7/25, 9/8/25, & 9/9/25. Administration notes from 9/10/25 indicated .Seen by MD, was waiting for supply, md order to d/c and notify when available . On 9/11/25 at 11:20 A.M., a follow up interview was conducted with Resident 30. Resident 30 stated that she started her chemotherapy medication on 8/15/25, at the hospital. Resident 30 stated she thought the hospital had given her three packages of medication before discharge, but she had left them at the hospital by mistake along with her other medications. Resident 30 stated that on 8/30/25, the Admissions Director (AD) went to the hospital to pick up all her medications, and when she returned to the facility, she brought them to her Licensed Nurse (LN) that day, but she didn't remember who the LN was. Resident 30 stated that day, the LN sent all her other medication home with her boyfriend but kept the chemotherapy pills in the cart. Resident 30 stated that on 9/5/25 the LN stated they were out of the chemotherapy pills, but she was unsure about who the LN was. Resident 30 stated she believed two packages were missing, but she was unsure what happened. On 9/11/2025 at 11:29 A.M., an interview with the AD was conducted. The AD stated that on 8/30/25 she went to the hospital to pick up all of Resident 30's medications that were left behind when she (continued on next page)		

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/2025 at 2:38 P.M. an interview with the Director of Nursing (DON) 2 was conducted. DON 2 stated that LN 25 forgot to notify physician that Resident 30's chemotherapy medication was about to expire, and he should have. DON 2 stated the importance of notifying physicians when medication is about to expire to communicate resident's needs and prevent lapses in medication. The DON 2 stated that LN 25 should have filled out an inventory sheet for Resident 30's personal medication upon receipt to accurately account for Resident 30's medication and to prevent missing medication or diversion. DON 2 stated that LN 11 should have documented accurately in the MAR and progress note to provide clear communication that accurate medication administration occurred and to accurately account for Resident 30's personal medication. Review of facility policy titled Pharmacy Services, Medication Administration/med carts and Storage dated 3/2025, indicated It is the policy of this facility to accurately, prepare, administer, and document medications as per physician's orders. The facility to also ensure the proper and safe storage of drugs and biologicals.8. All specialty medications from outside pharmacies or brought by family must have an account sheet to reflect number of medications received. 2. A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included history of Major Depressive Disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest). On 9/11/2025 at 3:26 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 42's antipsychotic medication monitoring for SE included, .Sedation [sleepiness], Dry mouth, constipation, slurred vision, EPS [extrapyramidal symptoms-uncontrolled movements], Weight gain, edema, Postural Hypotension . LN 1 stated there was no documentation found in Resident 42's clinical chart to support that postural hypotension (a drop in blood pressure from standing after lying or sitting down) was being monitored. LN 1 stated Resident 42 could have a syncope (fainting) episode, feel dizzy, experience headaches and could sustain an injury from fall accidents due to adverse SE of the antipsychotic medication. On 9/11/25 a review of Resident 42's psychotropic (medications that affects behavior, mood, thoughts, or perception) care plan initiated 7/4/25 was conducted. Resident 42's care plan goals indicated, .Will be/remain free of drug related complications, including .discomfort.hypotension. and interventions that indicated, .Monitor/record/report to MD prn [as needed] side effects and adverse reactions of psychoactive Medications. On 9/12/2025 at 11:43 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated her expectations were for the LNs to be implementing the monitoring of Resident 42's SE for postural hypotension with her antipsychotic medication use. DON 1 stated it was important that postural hypotension was monitored closely to prevent accidents such as falls. DON 1 further stated it was important for LNs to implement monitoring of SE that may be out of range findings to report to the MD and pharmacy for medication review and make recommendations that provide safety and professional standards of care for residents with antipsychotic (medication for mood, behavior, or thinking) medications. 3. Per the facility's admission Record, Resident 11 was admitted to the facility on [DATE] with diagnoses to include diabetes (unstable blood sugar levels). On 9/11/25 a review was conducted of Resident 11's medical record. Per the facility's Medication Administration Record (MAR) dated 9/1/25 &ndash; 9/30/25, Resident 11 had an order for Humulin (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Palomar Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 N Fig Street Escondido, CA 92025	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin (a medication to treat high blood sugar) with meals. There was no documentation to show the facility administered her 7 A.M. dose on 9/8/25 or her 12 P.M. dose on 9/4/25, 9/8, or 9/10. On 9/11/25 a review was conducted of Resident 11's progress notes. There were no progress notes on 9/4/25, 9/8, or 9/10 to explain the missing doses of Humulin insulin. On 9/11/25 at 3:24 P.M., an interview and record review was conducted with Licensed Nurse (LN) 2. LN 2 stated, she forgot to sign on the MAR that she administered the Humulin insulin on 9/4/25 and 9/10. On 9/12/25 at 9:07 A.M., an interview was conducted with LN 13. LN 13 stated, she gave Resident 11 both doses of Humulin insulin on 9/8/25, but she did not sign them on the MAR at the time of administration. On 9/12/25 at 11:20 A.M., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated, the LNs should have documented giving Resident 11's Humulin insulin at the time of administration. The facility's policy titled, Medication Administration/ med carts and Storage, revised 3/2025, did not have specific guidance to staff on when they should have documented their medication administration. 4. Per the facility's admission Record, Resident 8 was admitted to the facility on [DATE], with a diagnosis of Late Syphilitic Neuropathy (a neurological complication that occurs as a result of untreated or inadequately treated syphilis [A bacterial infection usually spread by sexual contact] infection). During an interview on 9/12/2025 at 9:10 A.M. with Licensed Nurse 13 (LN13), LN13 stated I had not documented the medications I had given. I have them all written down and plan to get them in today. I should document as they are given to prevent errors. During an interview on 9/12/2025 at 9:25 A.M. with Director of Nursing 2 (DON2), DON2 stated The expectation is that documentation occurs at the time it is given. If it isn't, the resident may get too much medication or not enough. LN13 should have documented. During a review of Resident 8's Medication Administration Record (MAR) for the month of September 2025, the MAR printed at 6:21 P.M. on 9/11/25 indicated that on 9/8/2025: The 12:00 P.M. dose of Buspirone HCL (medication to treat depression) 10 milligrams (mg) was not given. The 8:00 A.M. and 12:00 P.M. doses of Gabapentin (medication to treat pain) 600mg were not given. During a review of the facility's policy and procedure titled Policy/Procedure-Nursing Clinical: Pharmacy Services: Medication Administration/ med carts and Storage reviewed March 2025, the policy indicated, It is the policy of this facility to accurately prepare, administer and document medications as per physician's orders. The facility was unable to provide a policy and procedure on Nursing role with documentation and monitoring.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow standardized recipes during meal preparation on the tray line. This deficient practice placed 69 residents at risk for receiving meals that were not consistent, nutritionally adequate, or in line with physician orders and resident preferences. Findings: A review of the facility recipe on 9/11/25 was conducted. The recipe for Zesty Lasagna was used for a serving size of 72 was as followed:- Ground Turkey 6 lbs [pounds] Onion, Chopped 1 1/2 lbs Oregano, dried 3/8 cup Thyme, ground 1 TBSP [tablespoon] Cayenne pepper 3/4 tsp [teaspoon] Garlic Powder 1 1/2 Tbsp Basil, dried 1 Tbsp + 3/4 tsp Tomato Sauce 5 Qts [Quarts] + 1 Cup Tomato Paste 2 1/4 cups Large, pasteurized eggs, slightly beaten 15 Cottage Cheese 4 1/2 lbs Mozzarella cheese, shredded 3 lbs 12 oz [ounce] Parmesan cheese, grated, garnish As Desired Lasagna noodles, wheat or white 3 lbs 12 oz Boiling water 3 Gal [gallon] On 9/11/2025 at 9:26 A.M., an observation and interview was conducted with the Cook, in the kitchen during meal preparation for lunch. The [NAME] had already measured the turkey that was on the stove then measured onions on a scale as per recipe. The [NAME] used a green scoop (equivalent to 1/3 cup) to scoop dried oregano. The oregano recipe was for 3/8 cup, but the cook stated he was unable to find the ivory scoop (equivalent to 3/8 cup). The [NAME] continued to proceed with the recipe and used the same tablespoon and teaspoon without washing in between for thyme, cayenne, garlic powder then mixed all the dried ingredients together (including the 1/3 cup of oregano). The [NAME] then proceeded with the pasteurized eggs, cottage cheese, and mozzarella cheese per recipe. The [NAME] then mixed cottage cheese, mozzarella cheese and sprinkled an unmeasured amount of parmesan cheese with pasteurized eggs. The cook stated he mixed the parmesan cheese as desired unless a resident stated they did not want parmesan cheese. The [NAME] stated they did not have individual packets of parmesan cheese to give residents as to why he mixed the parmesan cheese. The [NAME] had already prepared the tomato sauce, tomato paste, and ground beef that was on the stove then combined them together along with the dried ingredients then mixed them together with the onions in the pot. On 9/11/2025 at 12:15 P.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated it was important that the [NAME] used appropriate portions and followed the recipe. The DS stated not using the right amount of measurements such as the wrong scoop (green scoop versus ivory scoop) could affect the taste, and nutritional value of the meal. A review of the facility's policy and procedure titled, Meal Service dated 2023, indicated . Meals that meet nutritional needs of the resident will be served in an accurate and efficient manner .		

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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. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the facility kitchen for 69 residents when:1. The chlorine (common chemical cleaner that kills germs, bacteria, and algae) level with the low-temperature dishwasher was below the required sanitation (reduces harmful bacteria on surfaces) level to fully sanitize and clean dishware and cookware.2. The scoop drawer was unorganized, creating a risk for kitchen staff to touch multiple utensils with unclean hands.These deficient practices placed all 69 residents at risk for foodborne illness, cross-contamination, and unsafe meal service.Findings:1. On 9/9/2025 at 8:46 A.M., an initial kitchen tour observation was conducted with the Cook. The [NAME] tested the chlorine levels for the low-temperature dishwasher with a test strip and placed the test strip on a cookware surface. The chlorine test strip turned light purple that indicated 10 parts per million (PPM- a unit used to describe very small concentrations of a substance in a larger solution) according to the chlorine test strip tube. The [NAME] stated he did not know the chlorine levels ranges for sanitizing dishware and cookware with the low-temperature dishwasher. The [NAME] stated it was important for the chlorine levels to be within range to sanitize dishware and cookware to kill bacteria, and prevent food borne illness that can cause infection.On 9/9/25 at 8:57 A.M., a document titled Dish Machine Temperature Log was reviewed. The document section for Litmus [piece of paper used to figure out if a liquid is an acid or a base] Strips indicated a range of 50-100.On 9/10/2025 at 8:48 A.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated that the chlorine test on litmus paper should be within the range of 50-100 PPM to properly sanitize dishware and cookware. The DS stated that it was important that the chlorine levels be within range to prevent food-borne illnesses for residents that are served food from the kitchen.A review of the facility's policy and procedure titled, Sanitation dated 2003, did not provide sanitation testing and monitoring on low-temperature dishwashing machines.2. On 9/11/2025 at 9:26 A.M., an observation and interview was conducted with the Cook, during meal preparation in the kitchen. The [NAME] looked for scoops in a drawer while trying to prepare measurements for dried ingredients for a recipe. Another kitchen employee (cook resource) and the Dietary Supervisor (DS) helped to look for appropriate scoops in the same drawer with their hands touching and moving around the scattered scoops in the drawer.On 9/11/2025 at 12:15 P.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated they (the cook resource, [NAME] and DS) were all trying to find the right scoop that the [NAME] needed. The DS acknowledged that different hands were touching the scattered scoops in the drawer (the cook resource, [NAME] and DS). The DS stated the scoop drawer was, messy and should be organized to easily get the scoops needed without having to touch everything else that was in the drawer to prevent cross contamination. A review of the facility's policy and procedure titled, Sanitation dated 2003, indicated .All utensils, counters, shelves, and equipment shall be kept clean .		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure consents were signed by the appropriate person for one of four residents (Resident 8). This failure had the potential for Resident 8 to receive medications for which they did not know the risks and benefits. Findings: Per the facility's admission Record, Resident 8 was admitted to the facility on [DATE], with a diagnosis of Late Syphilitic Neuropathy (a neurological complication that occurs as a result of untreated or inadequately treated syphilis [A bacterial infection usually spread by sexual contact] infection). During an interview on 9/11/2025 at 8:38 A.M. with Certified Nursing Assistant 31 (CNA31), CNA31 stated capacity was when a resident is alert and oriented and can make decisions for themselves. If they do not have the capacity, they cannot sign a consent form. The responsible party will need to sign the consent. During an interview on 9/11/2025 at 8:44 A.M. with Licensed Nurse 3 (LN3), LN3 stated capacity means they can make decisions for themselves. If they do not have capacity, they cannot make decisions or sign consents. LN3 further stated A person without capacity should not be asked to sign a consent. It would not be valid. During an interview on 9/11/2025 at 9:00 A.M. with the Director of Staff Development (DSD), the DSD stated the resident was not alert and oriented. The DSD further stated that They (the resident) cannot make decisions on their own. They should not be asked to sign a consent form. The consent would not be valid. During an interview on 9/12/2025 at 9:25 A.M. with the Director of Nursing 2 (DON2), DON2 stated Mental capacity is the ability to understand what is being said, what are the risks and benefits. If they (the Resident) don't (have capacity), we still involve them but also contact the Resident Representative. If the resident does not have capacity the consent would not be valid. If it is an invalid consent, then the resident might get medication they shouldn't be getting. During a record review of Resident 8's Electronic Medical Record (EMR), the Nurse Practitioner note dated January 24, 2025, the note indicated that for Decision Making: Patient does not have capacity to make medical decisions. During a record review of Resident 8's Electronic Medical Record (EMR), the document titled Consent for Treatment: Use of Sedative-Hypnotic[sleep] Medication dated 2/12/2025, was signed by Resident 8 only. Medication: Zolpidem Tartrate 5 milligrams. During a record review of Resident 8's Electronic Medical Record (EMR), the document titled Consent for Treatment: Use of Anti-Anxiety[restlessness] Medication dated 2/12/2025, was signed by Resident 8 only. Medication: Buspirone HCL 100 milligrams. During a record review of Resident 8's Electronic Medical Record (EMR), the document titled Consent for Treatment: Use of Other medication used as Psychotropic [medication for mood regulation] dated 05/07/2025, was signed by Resident 8 only. Medication: Valproic Acid 250 milligrams per 5 milliliters. During a record review of Resident 8's Electronic Medical Record (EMR), the document titled Consent for Treatment: Use of Other medication used as Psychotropic dated 06/12/2025, was signed by Resident 8 only. Medication: Gabapentin (pain medication) 600 milligrams. The facility did not provide a policy and procedure document regarding informed consent.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to keep one out of 21 sampled residents' (79) call bell within reach. This failure had the potential to prevent Resident 79 from summoning help when needed and preventing him from meeting his care needs. Findings: Review of the Admissions Record for Resident 79 indicated he was admitted on [DATE] for diagnoses which included: Spastic Quadriplegic Cerebral Palsy (a type of palsy [the loss of the ability to move] that affects all four limbs (arms and legs), Muscle Weakness, and Neuromuscular Dysfunction of bladder (a condition where the nerves and muscles that control bladder function are impaired, leading to abnormal urinary control). Review of Minimum Data Set (MDS-mandated clinical assessment of all residents in Medicare and Medicaid-certified nursing homes) Section C-Cognitive Patterns, dated 8/8/25, for Resident 79 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive (thinking processes) impairment. On 9/9/25 at 3:40 P.M., Resident 79 was observed verbally asking for a urinal. Resident 79's call light was observed on the floor. On 9/9/25 at 3:42 P.M., an observation of Resident 79's call bell and interview with Certified Nursing Assistant (CNA) 21 was conducted. CNA 21 stated that Resident 79's call light should be within reach, so he could make his needs known. On 9/9/25 at 3:46 P.M., an observation of Resident 79's call bell and interview with Licensed Nurse (LN) 22 was conducted. LN 22 stated Resident 79's call light should be within reach, so he could make his needs known. On 9/12/2025 at 2:47 P.M., an interview with the Director of Nursing (DON) 2 was conducted. DON 2 stated that all residents' call lights should be within reach of the residents to provide the residents the care that they need. Record review of facility policy titled Resident's Rights, Accommodation of Needs, dated 3/2023, indicated that it is the policy of this facility to provide accommodation of reasonable needs to the residents while in the facility. Examples of Accommodation of needs is not limited to the following. Call lights		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's right to make choices for two of three residents (Resident 42, Resident 24) sampled when a shower was not provided as requested, and vitamins were taken from a resident's room. This deficient practice placed Resident 42 and Resident 24 at risk for not having their dignity, comfort, and personal preferences respected, which could negatively impact quality of life. Findings: 1. A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included history of Major Depressive Disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident 42's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/10/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 42 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 10:13 A.M., an observation and interview was conducted with Resident 42, in Resident 42's room. Resident 42 was lying in bed in an upright position wearing a facility gown. Resident 42 stated she was really mad that she did not get a shower yesterday (9/8/25) when she requested for one. Resident 42 stated she was told she was not allowed to have one because she had an intravenous line (IV-flexible plastic tubing to deliver medications or fluids) on her left arm. Resident 42 stated she was ready to get a shower but had not received one. On 9/9/2025 at 2:34 P.M., an observation, and interview was conducted with Resident 42, in Resident 42's room. Resident 42 stated that she still did not get a shower and was still wearing the same facility gown from the morning. Resident 42 stated she did not feel clean. On 9/10/2025 at 3:13 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was given a sponge bath on 9/8/25 as documented by a registry certified nursing assistant (CNA). LN 1 stated Resident 42's shower schedule was given on Mondays and Thursdays. LN 1 stated a sponge bath was not the same as a shower. On 9/12/2025 at 7:49 A.M., an observation and interview was conducted with CNA 1, in Resident 42's room. Resident 42 had a shower/bathing calendar on her dresser cabinet wall by the bathroom. CNA 1 stated Resident 42 was scheduled every Monday and Thursday to receive a shower if Resident 42 wanted one. CNA 1 stated Resident 42 was on a B bed which meant she received showers during the P.M. (late afternoon-evening) shift. CNA 1 stated bed baths are not considered showers and stated she preferred to give her assigned residents showers because the benefits include skin checks and was preferred to get the whole body cleaned from head to toe. CNA 1 stated Resident 42 should have received a shower if she requested a shower and not a bed bath because that was her preference and her right to receive one. CNA 1 stated Resident 42 would not feel good and may feel bad that her request was not honored. CNA 1 stated showering would make Resident 42 feel stimulated, happy and feel good about herself. On 9/12/2025 at 8:05 A.M., an interview was conducted with LN 2. LN 2 stated that all facility (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents can request showers at anytime and not limited to their shower/bathing schedule. LN 2 stated Resident 42 should have received a shower and not a bed bath because they were not the same. LN 2 stated Resident 42's preference for a shower should have been honored to preserve her rights and dignity to make decisions about her care. LN 2 stated Resident 42 is alert and knows what she likes and would feel bad if that preference was not honored because this would make her feel bad like nobody cares. On 9/12/2025 at 11:02 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated her expectations were that nursing staff honor Resident 42's preference for a shower. DON 1 stated a bed bath was not the same as a shower and if Resident 42 wanted a shower, then her preference had to be honored because it was Resident 42's right to have her preferences respected. A review of the facility's policy and procedure titled, Resident Rights Accommodation of needs dated 5/2025, indicated .Examples of Accommodation of needs but is not limited to the following .Showers 2. Per the facility's admission Record, Resident 24 was admitted to the facility on [DATE] with diagnoses to include generalized anxiety (worry) disorder. On 9/9/25 at 2:44 P.M., an interview was conducted with Resident 24. Resident 24 stated, she had vitamins in her room which went missing. Resident 24 further stated, she told the administrator and other facility staff about her missing vitamins but they told her they couldn't find them and didn't do anything to help her. On 9/10/25 at 4:18 P.M., an interview was conducted with the Administrator (ADM). The ADM stated, the facility searched resident rooms throughout the facility and took Resident 24's vitamins from her room. On 9/12/25 at 9:16 A.M., an interview was conducted with the Social Worker (SW). The SW stated, they took Resident 24's vitamins because she was not allowed to store them in her room. The SW further stated, she did not remember if anyone from nursing was involved in the process of taking Resident 24's vitamins. On 9/12/25 at 9:20 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated, when Resident 24's vitamins were taken, no one notified the doctor. DON 1 further stated, when they first took her vitamins, someone should have explained to Resident 24 why they had to take her vitamins, and they should have notified her doctor at that time to obtain an order to give her the vitamins she wanted. DON 1 further stated, they should have evaluated Resident 24 for the ability to self-administer her vitamins. On 9/12/25 at 9:23 A.M., an observation was conducted of Resident 24's vitamins with DON 1. The bag of vitamins was labeled 9/6/25 with Resident 24's name. The bag included a vision defense dietary supplement, hair skin and nails dietary supplement, eye health supplement, and Vitamin E (supplement for skin health). There was no documentation from the time of the incident. Per the facility's policy titled, Resident's Rights Subject: Accommodation of Needs, revised May 2025, Staff will Review resident's preferences and accommodate their needs.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to help formulate (assist) an advance directive (AD-a legal document indicating resident preference on end-of-life treatment decisions) for one of three residents (Resident 42) sampled. This deficient practice placed Resident 42 at risk for not having their medical treatment wishes known or respected during an emergency or serious illness. Findings: A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included a history of Major Depressive Disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident 42's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/10/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 42 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 4:05 P.M., a record review was conducted on Resident 42's electronic health record (EHR) and live chart. Resident 42's Physician Ordered Life Sustaining Treatment (POLST) document was marked .No Advance Directive. On 9/10/2025 at 1:57 P.M., an interview was conducted with Resident 42, in Resident 42's room. Resident 42 stated prior to transferring to the facility the acute Hospital had given her information about an AD but was not completed. Resident 42 stated she was not asked if she had an advanced directive. Resident 42 stated she would have wanted assistance to formulate an advanced directive if it was offered at the facility but was not offered. On 9/10/2025 at 3:17 P.M., an interview and record review was conducted with the Social Service Director (SSD). The SSD stated she completed Resident 42's Social Service Assessment/Evaluation (SSAE) on 6/9/25. The SSD stated Resident 42's SSAE was not checked off that she asked Resident 42 if she required assistance to formulate an AD or had an AD. The SSD stated she only checked off that Resident 42 would be using the POLST. The SSD stated that it was important to know Resident 42's health care decisions should an emergency or life-threatening illness happen to Resident 42 to respect Resident 42's health care decisions and for staff to know what to do during an emergency and/or life threatening illness to care for her in a dignified manner. The SSD stated that a POLST was not an AD and therefore cannot be treated as an AD. On 9/12/2025 at 10:59 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated her expectations was for the SSD to help Resident 42 to help formulate an AD because a POLST was not an AD. DON 1 stated it was important for facility staff to know what Resident 42's AD should an emergency arise so that Resident 42's health care decisions were respected and dignified when Resident 42 can no longer make health care decisions for herself. A review of the facility's policy and procedure titled, Residents Rights Advanced Directive/POLST revised 6/20/2025, indicated .to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.		

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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** Based on observation, interview, and record review, the facility failed to ensure two of 21 residents (Resident 85 and Resident 25) minimum data set (MDS - a federally mandated resident assessment tool) was coded accurately when: 1. Resident 85's Hospice status was not coded. 2. Resident 28's unstageable pressure ulcer was not coded as present on admission. As a result Resident 85 and Resident 28's MDS were sent to the federal database with inaccurate information. Findings: 1. A review of Resident 85's admission Record indicated Resident 85 was admitted to the facility on [DATE] with diagnoses which included history of Cerebral Infarction (stroke- disrupted blood flow to the brain). A record review of Resident 85's MDS dated [DATE] indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of six points out of 15 possible points which indicated Resident 85 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 9:56 A.M., an observation, and interview was conducted with Resident 85, in Resident 85's room. Resident 85 would smile and say a-ha but was unable to carry on a full conversation. Resident 85 had oxygen being administered through his nose by an oxygen concentrator placed on the floor with a humidifier attached to the oxygen tubing. On 9/9/2025 at 4:14 P.M., a record review was conducted on Resident 85's clinical chart. Resident 85 had hospice active orders since 3/13/25 that indicated, .patient admitted to hospice. [Name of Hospice].with dx [diagnosis] of cerebrovascular disease [conditions that affect blood flow to your brain]. On 9/10/2025 at 3:45 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 85 has been with (Name of Hospice) since 3/13/25. LN 1 stated Resident 85's hospice status was never discontinued. On 9/11/2025 at 11:27 A.M., a record review was conducted on Resident 85's MDS assessment reference date (ARD) 6/20/25 quarterly assessment. Resident 85's MDS Section O was not coded for Hospice care while at the facility. On 9/12/2025 at 9:47 A.M., an interview and record review was conducted with the MDS Coordinator (MDSC), in the MDS office. The MDSC stated Resident 85's quarterly MDS ARD 6/20/25 was coded inaccurately in Section O. The MDSC stated he was unable to find documentation that Resident 85's hospice orders were discontinued during the MDS look-back period (within the last 14 days of the ARD). The MDSC stated that Resident 85's MDS was coded incorrectly and was sent to Centers for Medicare and Medicaid Services (CMS-federal database) for reimbursement, and quality measures of the facility. The MDS stated he needed to do a modification to Resident 85's MDS and re-send the correct data to CMS. On 9/12/2025 at 11:21 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated that her expectations was for the MDS to be coded accurately to reflect Resident 85's health status. DON 1 stated the MDSC had to modify the MDS and re-send to CMS. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Resident Assessment Instrument [RAI] dated 10/1/2023, indicated .Each person completing the MDS attests to the accuracy by affixing his/her electronic signature to that section of the MDS . 2. Per the facility's admission Record, Resident 28 was admitted to the facility on [DATE] with diagnoses to include pressure ulcers (wounds caused by sitting or lying in one position for too long). On 9/9/25 at 12:04 P.M., an interview was conducted with Resident 28. Resident 28 stated he had pressure ulcers, but already had all of them prior to admitting to the facility. On 9/11/25 a review was conducted of Resident 28's medical record. Per the facility's LN (Licensed Nurse)- Skin Pressure Ulcer Weekly, dated 3/21/25, Resident 28 had four stage four (a deep wound exposing bone or muscle) pressure ulcers, and one unstageable (a wound of uncertain depth) pressure ulcer, all present on admission. Per the facility's MDS, dated [DATE], Resident 28 had four stage four pressure ulcers and zero unstageable pressure ulcers on admission to the facility. On 9/11/25 at 3:30 P.M., an interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC stated, Resident 28 had four stage four pressure ulcers and one unstageable pressure ulcer on admission, but the unstageable pressure ulcer was not documented on Resident 28's 3/19/25 MDS. The MDSC further stated, the facility's usual MDSC should have documented the unstageable pressure ulcer on the MDS. On 9/12/25 at 11:17 A.M., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated, the MDSC should have documented the unstageable pressure ulcer on the 3/19/25 MDS. Per the facility's policy, titled Policy/Procedure &ndash; Resident assessment Instrument, updated 10/1/23, 6) Each person completing a section of the MDS attests to its accuracy by affixing his/her electronic signature to that section of the MDS.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer a resident with a new mental disorder to the state designated authority for evaluation for one of three sampled residents (10).As a result, the facility may not have been providing necessary services to Resident 10.Findings:Per the facility's admission Record, Resident 10 was admitted to the facility on [DATE], and had a diagnosis of major depressive disorder (depression - a serious mental illness) dated 7/31/24.Per the facility's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 6/6/24, Resident 10 was negative for serious mental illness, and the case was closed.On 9/11/25 at 11:26 A.M., an interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC stated, if a resident had a new diagnosis of a serious mental illness such as major depressive disorder, then the facility should have done a new resident review and updated the PASRR.On 9/11/25 at 3:36 P.M., an interview and record review was conducted with the Admissions Director (AD). The AD stated, the latest PASRR completed for Resident 10 was dated 6/6/24.On 9/12/25 at 8:06 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated, the PASSR should have been updated when Resident 10 had a new diagnosis of major depressive disorder.Per the facility's undated policy, titled, Resident assessment Subject: PASRR, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately screen newly admitted residents for a mental disorder for two of three sampled residents (9, 11).As a result, the facility may not have been providing necessary services to Resident 9 and Resident 11.Findings:1. Per the facility's admission Record, Resident 9 was admitted to the facility on [DATE] with diagnoses to include Huntington's disease (a disorder that effects movement, thinking, and behavior), post-traumatic stress disorder (PTSD - a mental illness caused by a traumatic event), and major depressive disorder (depression - a mental illness).Per the facility's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 10/17/24, Resident 9 did not have a diagnosed mental disorder such as depressive disorder or mood disturbance, and did not require a level 2 mental health evaluation.On 9/12/25 at 8:18 A.M., an interview and record review was conducted with the Admissions Director (AD). The AD stated, the latest PASRR completed for Resident 9 was dated 10/17/24. The AD further stated, the MDS nurse checked the PASSR of newly admitted residents for accuracy.On 9/12/25 at 11:22 A.M., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated, the facility should have reviewed Resident 9's admission PASSR for accuracy and updated it if it was inaccurate.2. Per the facility's admission Record, Resident 11 was admitted to the facility on [DATE] with diagnoses to include schizophrenia (a serious mental illness of disconnection from reality).Per the facility's Notice of Exempted Hospital Discharge, dated 8/21/24, If the individual remains in the NF (Nursing Facility) longer than 30 days, the facility must resubmit a new level 1 Screening as a Resident Review on the 31st day.Per the facility's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 2/13/25, Resident 11 was positive for the serious mental illness of schizophrenia.Per the facility's Notice of PASRR Level 1 Screening Results, dated 2/13/25, a level 2 mental health evaluation was required.Per the facility's Notice of Attempted Evaluation, dated 2/13/25, Unable to complete level II evaluation for serious mental illness.Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. The case is now closed. To reopen, the facility must resubmit a new Level I Screening.On 9/11/25 at 3:36 P.M., an interview and record review was conducted with the AD. The AD stated, Resident 11 had PASSR screenings conducted on 8/21/24 and 2/13/25.On 9/11/25 at 3:53 P.M., an interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC stated, the facility should have completed Resident 11's PASSR reevaluation on the 31st day of her admitting to the facility. The MDSC further stated, Resident 11's positive PASSR 1 on 2/13/25 should have triggered a PASSR level 2 review, and the facility should have followed up to see why the evaluation was not completed.On 9/12/25 at 11:22 A.M., an interview was conducted with DON 2. DON 2 stated, the facility should have reevaluated Resident 11's PASSR.Per the facility's undated policy, titled, Resident assessment Subject: PASRR, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State.		

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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** Based on observation, interview and record review the facility failed to develop a person-centered comprehensive care plan that identified a language preference for one of seven residents (Resident 61) sampled. This deficient practice placed Resident 61 at risk for having care provided that did not reflect their individual goals, needs, and choices, that could negatively impact communication, dignity, and quality of care. Findings: A review of Resident 61's admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses which included history of Respiratory Failure (inability of the respiratory system to maintain an adequate blood oxygen level). A record review of Resident 61's minimum data set (MDS - a federally mandated resident assessment tool) dated 8/26/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 11 points out of 15 possible points which indicated Resident 61 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 12:25 PM a record review was conducted on Resident 61's clinical chart included:- Resident 61's MDS comprehensive assessment dated [DATE] indicated, Resident 61's preferred language was Vietnamese.- Resident 61's Social Services Assessment/Evaluation dated 8/27/25 indicated, .Language. Resident has verbalized the need of an interpreter to communicate with doctor or health care staff . Answered yes and indicated .Primary Language .Vietnamese. On 9/10/2025 at 7:42 A.M., an observation and interview was conducted with Resident 61's son, in Resident 61's room. Resident 61 was lying in bed asleep. Resident 61's son stated Resident 61 was not fluent in English and spoke Vietnamese. Resident 61's son stated Resident 61 does not eat the food at the facility and brought Resident 61 food from home. On 9/11/2025 at 8:52 A.M., an interview that was translated in Vietnamese by translator services was conducted with Resident 61, in Resident 61's room. Resident 61 stated she did not know how to speak English. Resident 61 stated she spoke Vietnamese and that her son spoke for her when he visited her. Resident 61 stated she cooked from home and her preference was Vietnamese food from home because she did not like American food that was being served at the facility. Resident 61 stated the facility did not offer her alternatives or mention that there was alternatives if she did not like the food. Resident 61 stated there was a language barrier with the staff to communicate her needs when her son was not with her at the facility. Resident 61 stated she was able to understand a little English but not fluently. On 9/11/2025 at 11:28 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 3, outside of Resident 61's room. CNA 3 stated she was Resident 61's CNA. CNA 3 stated Resident 61 did understand a little bit of English if asked simple questions. CNA 3 stated alternative food choices were not offered because Resident 61 never asked for alternative options. CNA 3 stated she was unsure what language Resident 61 spoke and did not know of any co-workers that spoke Resident 61's language (Vietnamese). CNA 3 stated Resident 61 preferred food from home that her son would bring to the facility. CNA 3 stated Resident 61 did eat some food at the facility but would prefer to eat familiar food brought from home. On 9/11/2025 at 11:46 A.M., an observation and interview was conducted with Licensed Nurse (LN) 3, in Resident 61's room. LN 3 stated he was Resident 61's nurse. LN 3 stated usually residents who need assistance with translation have signs to use or a communication board in their rooms to better assist with translation. LN 3 stated Resident 61 did not have any written or visual translation and/or communication methods accessible in Resident 61's room. On 9/11/2025 at 11:49 A.M., an interview was conducted with CNA 3. CNA 3 stated she did not know if the facility offered translation services and further stated it was important to honor Resident 61's language preferences to better understand and communicate Resident 61's needs. CNA 3 stated Resident 61 had no written or visual translation and/or communication methods she had used to communicate with Resident 61. On 9/11/2025 at 11:53 A.M., an interview and record review was (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with LN 3. LN 3 stated Resident 61's care plan did not include Resident 61's language preference. LN 3 stated it was important that language preference be included in Resident 61's care plan to better communicate with Resident 61's health care needs. LN 3 stated Resident 61 preferred Vietnamese food and had lost weight as compared to her initial weight taken on 8/27/25 at 108.2 lbs (pounds) and on 9/2/25 at 103.8 lbs possibly due to meal intake and food preference. On 9/12/2025 at 11:05 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated Resident 61's care plan should include Resident 61's language preference as captured in Resident 61's comprehensive assessment to provide person-centered care. DON 1 stated her expectations was for facility staff to provide a person-centered plan of care that is needed to improve communication, dignity and quality of life for Resident 61. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning revised 10/2023, .It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an activities program that met the interests and needs for one of seven sampled residents (Resident 42).As a result, Resident 42 was not invited to group social activities (movie social, manicures, social coffee, arts and crafts and any social games such as BINGO) that did not support Resident 42's right to participate in activities of choice and placed Resident 42 at risk for social isolation, boredom, and decreased quality of life.Findings:A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included history of Major Depressive Disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest).A record review of Resident 42's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/10/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 42 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/25 at 2:41 P.M., an observation and interview was conducted with Resident 42, in Resident 42's room. Resident 42 was lying in bed wearing a facility gown with sunny weather outside appearing from the window. Resident 42 stated she wanted to get out of bed so much and could not stand being in her bed. Resident 42 stated she was not given an activities calendar and further stated, They don't ask anymore because they assume I don't want to go. Resident 42 stated she liked social activities such as painting and drawing, manicures, BINGO (starts at 2PM every day except Wednesday and Friday), and social coffee. Resident 42 stated she did not do anything all week but lay in her bed. On 9/10/2025 at 2:02 P.M., an observation and interview was conducted with Resident 42, in Resident 42's room. Resident 42 was lying in bed wearing a facility gown with sunny weather outside appearing from the window. Resident 42 stated, They didn't give me an activity schedule today or get me out of bed. Resident 42 stated she would have wanted to join social activities today but was not asked.On 9/10/2025 at 2:03 P.M., an observation and interview was conducted with Activities Assistant (AA) 1, in Resident 42's room. AA 1 passed out an activities calendar to Resident 42 and dropped of the facility's newsletter called The Daily Chronicle. AA 1 stated Resident 42 liked to do social activities such as BINGO, and any social activities that were available. Resident 42 was lying down in bed and agreed with AA 1. AA 1 stated Resident 42 did not participate with social activities on Monday (9/8/25), yesterday (9/9/25) and today (9/10/25). AA 1 stated BINGO was offered on Monday (9/8/25) and yesterday (9/9/25) but Resident 42 did not go because she was not invited and assisted to go to the dining room for activities. AA 1 stated Resident 42 should have been invited and that this was important for Resident 42 because this activity made her happy and kept Resident 42 busy from feeling depressed (unhappy). On 9/10/25 a record review was conducted on Resident 42's clinical chart. - MDS dated [DATE] indicated, Resident 42's social activities were .somewhat important. favorite activities was .very important. going outside to get fresh air when the weather was good was .very important. and religious services .very important.- Resident 42's activity care plan initiated 6/16/25 indicated, . (Resident 42's first name) is dependent on staff for activities, cognitive stimulation, social interaction. and interventions (plans) to include .Invite to scheduled activities.- Resident 42's social activities from June 2025-September 2025 showed Resident 42 participated with social activities on:* July: 7/4/25, 7/9/25, 7/10/25, 7/11/25, 7/12/25, 7/13/25, 7/16/25, 7/17/25, 7/18/25, 7/20/25, 7/21/25, 7/25/25, 7/26/15, 7/27/25, 7/29/25, 7/31/25* August: 8/1/25, 8/2/25, 8/3/25, 8/4/25, 8/5/25, 8/6/25, 8/7/25, 8/8/25, 8/11/25, 8/12/25, 8/13/25, 8/14/25, 8/17/25, 8/18/25, 8/19/25, 8/20/25, 8/21/25, 8/23/25, 8/28/25, 8/29/25 * September: 9/3/25, 9/6/25, 9/7/25, 9/8/25On 9/12/2025 at 8:14 A.M., an interview was conducted with the Activities Director (AD). The AD stated it was her expectation that Resident 42 attend social activities of her choice and if Resident 42 liked BINGO, then Resident 42 should have been invited to join the activity when BINGO (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was scheduled. The AD stated it was important for Resident 42 to attend social activities because this kept Resident 42 stimulated, happy, and engaged thereby improving the quality of life at the facility. On 9/12/2025 at 10:51 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated it was important for Resident 42 to participate in activities of her choice because doing so kept Resident 42 active with social events to increase positive mood, happiness, and engaged with other residents that promotes a better quality of life. A review of the facility's policy and procedure titled, Quality of Life Activities Program revised 4/2025, indicated .Residents who wish to meet with or participate in social or religious activities, or other community activities, at or away from the facility, is encouraged to do so.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's (MD) orders for tube feeding for one of one resident (Resident 100) reviewed with enteral (refers to any method of feeding that uses the stomach to deliver nutrition and calories) nutrition.As a result Resident 100 did not receive enteral feeding at scheduled time as per MD order and potential risk for malnutrition. Findings:A review of Resident 100's admission Record indicated Resident 100 was re-admitted to the facility on [DATE] with diagnoses which included history of Malignant Neoplasm of Prostate (prostate cancer- an abnormal tumor located below the bladder in males).A record review of Resident 100's minimum data set (MDS - a federally mandated resident assessment tool) dated 5/31/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 100 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 12:25 P.M., a record review was conducted on Resident 100's clinical chart. Resident 100's care plans and physician (MD) active orders included:- Care plan initiated 9/9/25 indicated, .Requires Tube feeding (TF-soft, flexible plastic tubes through which liquid nutrition travel through the stomach) . Is dependent with tube feeding and water flushes. See MD orders for current feeding orders.- MD orders dated 9/9/25 indicated, .Enteral Feed Order Two times a day Continuous Water Flush of 60 ml [milliliter] /[per]hr[hour] x 18 hours to provide 1080 ml of H2O [water] in 24 hrs [hours] via enteral feed.- MD orders dated 9/10/25 indicated, . Enteral Feed Order two times a day Initiate [Brand of Nutrition] 1.5 via G-tube [gastrointestinal-through the stomach] start @ [at] 30ml/h and advance to 10 ml per shift to goal @ 70mL/h x18h with FW [sic] flushes 60mL q [every] 1h [one hour] On at 1400 [2PM], off at 0800 [8AM] next day.On 9/9/2025 at 12:09 P.M., an observation and interview was conducted with Resident 100, in Resident 100's room. Resident 100 stated that he was not sure if he ate or had TF running that day. Resident 100's TF machine was turned off with no water flushes or nutritional feedings hung on Resident 100's TF pole.On 9/11/2025 at 8:29 A.M., an observation and interview was conducted with Resident 100, in Resident 100's room. Resident 100's TF machine was turned off with no water flushes or nutritional feeding hung on Resident 100's TF pole. Resident 100 stated I think it's my final encounter. On 9/11/2025 at 3:36 P.M., an interview and record review was conducted with licensed nurse (LN) 1, at the nursing station. LN 1 stated Resident 100 had an ordered ultrasound on 9/11/25 at midnight due to abdominal swelling and pain. LN 1 stated that the ultrasound technician came to see Resident 100 as per nursing notes ultrasound completed at 12 P.M. on 9/11/25.On 9/11/2025 at 3:43 P.M., an observation and interview was conducted with LN 1, in Resident 100's room. Resident 100's TF machine was turned off with no water flushes or nutritional feeding hung on Resident 100's TF pole. LN 1 stated she was unsure what happened and why Resident 100's enteral feeding orders were not initiated at 2 P.M. LN 1 stated if Resident 100's TF was off all day Resident 100 could have complications to include dehydration (not enough water intake), hypoglycemia (low sugar levels), loss of consciousness (e.g. confusion, dizziness, weakness) and further health decline.On 9/11/2025 at 3:47 P.M., an observation and interview was conducted with Resident 100, in Resident 100's room. Resident 100 stated his TF was not given to him and had been off all day.On 9/11/2025 at 4:00 P.M., an interview and record review was conducted with LN 1, at the nursing station. LN 1 stated Resident 100 did not eat anything for breakfast but ate 45% of his lunch. LN 1 stated there was no baseline weight taken for Resident 100 upon admission but was taken on 9/10/25 at 135.4 lbs (pounds) without weight monitoring recommendations by the Registered Dietician (RD).On 9/12/2025 at 8:27 A.M., an interview and record review was conducted with the RD. The RD stated that the Dietary Supervisor (DS) opened his Nutrition Evaluation on 9/8/25 but did not complete Resident 100's assessment until 9/9/25 to get (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Palomar Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 N Fig Street Escondido, CA 92025	
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 100's weight. The RD stated weights are taken on Monday and Thursday. The RD stated he did not know his policy and procedure for when weights were supposed to be taken for new admissions. The RD stated Resident 100 was not within his ideal body weight (IBW) 180-184 lbs. The RD stated he had not observed Resident 100 eat but used data available to him via Resident 100's clinical chart. The RD stated if the MD placed an order at 2 P.M. for an enteral TF then the TF should be started according to the MD orders. The RD stated Resident 100 would not receive the full nutritional values from the TF and is at risk for malnutrition (poor nutrition that contributes to weight loss). On 9/12/2025 at 11:38 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated Resident 100's TF was not connected after 4 P.M., even though physician's orders required it to be started at 2 P.M. DON 1 explained that because of the delay, Resident 100 may not have received nutrition as ordered, which could prevent meeting Resident 100's caloric (units of energy that fuel essential body functions) and hydration (the body's ability to absorb water) needs. DON 1 stated her expectations were that TF orders be followed exactly as prescribed by the MD and carried out in a timely manner to ensure Resident 100 received adequate nutrition and hydration. A review of the facility's policy and procedure titled, Physician Orders dated 5/2025, indicated .It is the policy of this facility to accurately transcribe and implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care .		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess residents for the risk of bedrail entrapment (getting caught between the bed and the bedrail), review the risks and benefits of bedrails, and obtain informed consent prior to installing bedrails for two of three sampled residents (11, 98).As a result, Resident 11 and Resident 98 were placed at an increased risk of entrapment related injury.Findings:1. Per the facility's admission Record, Resident 11 was admitted to the facility on [DATE] with diagnoses to include muscle weakness.On 9/10/25 a review was conducted of Resident 11's medical record.The facility's LN(Licensed Nurse)-Restraint/Enabling Device/Safety Device Evaluation - V2, dated 1/28/25 was not filled out, and had all sections blank including the sections on consent and risks and benefits.The facility's LN-Restraint/Enabling Device/Safety Device Evaluation - V2, dated 2/24/25 was not filled out, and had all sections blank including the sections on consent and risks and benefits.On 9/10/25 at 3:16 P.M., an interview and observation was conducted with Resident 11. Resident 11's bed was observed to have bedrails attached. Resident 11 stated that she did not use her bedrails and wanted them to be removed.On 9/11/25 at 11:51 A.M., an interview and record review was conducted with the Medical Records Director (MRD). The MRD was unable to a bedrail consent, or a completed bedrail entrapment risk assessment in Resident 11's medical record. The MRD stated, the admissions nurse should have completed the 1/28/25 safety device evaluation, and the MDS (Minimum Data Set-resident assessment tool) nurse should have completed the 2/24/25 safety device evaluation.On 9/11/25 at 12:04 P.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated, the admissions nurse should have completed the 1/28/25 safety device evaluation, and the MDS nurse should have completed the 2/24/25 safety device evaluation. The DON further stated, that the bedrail entrapment risk assessment, reviewing the risks and benefits of bedrails, and obtaining informed consent should have been completed prior to installing bedrails.2. Per the facility's admission Record, Resident 98 was admitted to the facility on [DATE] with diagnoses to include age-related physical debility.On 9/11/25 at 4:07 P.M., an observation was conducted of Resident 98's bed. There were bedrails attached.On 9/12/25 at 8:28 A.M., an interview and record review was conducted with the MRD. The MRD stated, she was unable to find documentation of a bedrail entrapment risk assessment for Resident 98.On 9/12/25 at 11:04 A.M., an interview was conducted with DON 2. DON 2 stated, the bedrail entrapment risk assessment should have been completed for Resident 98.The facility did not have a policy on bedrails.		

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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** Based on observation, interview and record review the facility failed to accurately acquire, receive, and account for one of 21 sampled residents (30) personal chemotherapy medication. This failure had the potential for harm to Resident 30 related to missing ordered chemotherapy medications. Cross reference F658 Findings: Review of admission Record for Resident 30 indicated that resident was admitted on [DATE] for diagnoses which included: Joint replacement surgery, Muscle Weakness, Recurrent Dislocation (when the normal position of a joint or other part of the body is disturbed) of Left Hip, Malignant Neoplasm (an abnormal growth of cells that have the potential to invade and spread to other parts of the body) of Breast, Major Depressive Disorder (a serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). Review of Minimum Data Set (MDS-standardized assessment done in nursing homes) Section C-Cognitive (thinking) Patterns, dated 7/16/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition (thinking processes). On 9/9/25 at 8:53 A.M., during initial pooling, an interview with Resident 30 was conducted. Resident 30 stated she was supposed to be taking an oral chemotherapy (a medication for cancer) pill, Verzenio. Resident 30 stated that she believed she had three packages of seven pills each given to her by the hospital, and she was only able to take one package of seven at the facility. Resident 30 stated that she believed the facility lost two of the three packages. Review of physician orders dated 8/28/25, indicated Verzenio Oral Tablet 100 MG (milligram-unit of measure), Give 1 tablet by mouth two times a day for Breast Cancer. A record review of the Electronic Medication Administration Record (eMAR-an electronic record of medications given for a resident) Administration Notes for Resident 30 from 8/29/25 to 9/10/25 was conducted. Review indicated Verzenio was .Not available. on the following dates 9/5/25, 9/6/25, 9/7/25, 9/8/25, & 9/9/25. Administration notes from 9/10/25 indicated .Seen by MD, was waiting for supply, md order to d/c and notify when available .On 9/11/25 at 11:20 A.M., a follow up interview was conducted with Resident 30. Resident 30 stated that she started her chemotherapy medication on 8/15/25, at the hospital. Resident 30 stated she thought the hospital had given her three packages of medication before discharge, but she had left them at the hospital by mistake along with her other medications. Resident 30 stated that on 8/30/25, the Admissions Director (AD) went to the hospital to pick up all her medications, and when she returned to the facility, she brought them to her Licensed Nurse (LN) that day, but she didn't remember who the LN was. Resident 30 stated that day, the LN sent all her other medication home with her boyfriend but kept the chemotherapy pills in the cart. Resident 30 stated that on 9/5/25 that the LN stated that they were out of the chemotherapy pills, but she was unsure about who the LN was. Resident 30 stated that she believed two packages were missing, but she was unsure what happened. On 9/11/2025 at 11:29 A.M., an interview with the AD was conducted. The AD stated that on 8/30/25 she went to the hospital to pick up all of Resident 30's medications that were left behind when she was discharged . The AD stated that she received all of Resident 30's medication from the hospital nurse in a see-through plastic bag. The AD stated that she remembered only one packet of seven pills of Resident 30's chemotherapy medication in the bag with other medications. The AD stated that when she returned to facility, she gave the bag of medications to the nurse taking care of Resident 30, LN 25, to review with Resident 30. On 9/11/25 at 12:02 P.M., a phone interview was conducted with LN 25. LN 25 stated when he received Resident 30's medication from the AD, he went through all resident's medication with Resident 30. LN 25 stated he kept Resident 30's one box of chemotherapy pills containing seven individual pills. LN 25 stated he documented in the electronic medication record (EMR) the one box that was brought from the hospital, and he showed Resident 30 the one box and gave the other medications to Resident 30's boyfriend. LN 25 stated that the process for receiving personal medications from the resident was to (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	count the medication in front of the resident with resident and document when they give the resident the medication. On 9/11/25 3:35 P.M. an interview with Resident 30's nurse on duty, LN 26, was conducted. LN 26 stated the process for residents with personal non-formulary medications is to :1. Notify physician and pharmacist, 2. send medication to pharmacy to verify medication is what it is supposed to be, 3. get order by MD to approve giving said medication, 4. document medication name, dose, amount of tablets received, and consent to store medication, and 5. create a medication counting sheet. LN 26 stated the importance of properly receiving, accounting, and storing personal medication was to properly document the amount of medication that the resident brought to the facility and to prevent medicine from being lost or stolen. On 9/12/25 at 8:01 A.M., a follow up interview with LN 25 and record review of policy Pharmacy Services, Medication Administration/Med carts and Storage was conducted. LN 25 stated he did not make an account sheet to reflect the number of medications received per policy. LN 25 stated the importance of making an account sheet was to verify right medication, right dosage, right amount, and to prevent drug loss or diversion. On 9/12/25 at 11:45 A.M., a concurrent interview with LN 11 and review of the electronic Medication Administration Record (eMAR) for Resident 30 was conducted. Resident 30's eMAR indicated that LN 11 documented he gave Resident 30's chemotherapy on 9/7/25, despite the last dose in facility was given on 9/5/25. LN 11 stated he didn't remember if the chemotherapy drug was in the cart or if there had been account sheet. LN 11 stated he thought Resident 30's boyfriend had dropped off medications. LN 11 stated he thought the process for receiving resident's personal medication was . to lock the medication in the med room, administer it, and sign off. LN 27 was not aware that aware that he should verify the medication with MD or Pharmacist or that he should make an inventory sheet for personal medication brought from home. LN 27 insisted he gave the medication, despite the facility not having the chemotherapy medication since 9/5/25 as documented in Medication Administration Notes. On 9/12/25 at 1:30 P.M. a concurrent interview with Resident 30 and LN 25 was conducted. Resident 30 stated she thought she remembered three packets of medication being brought to facility, but was not completely sure. LN 25 stated he received the medication from the AD, and then reviewed each of the medications with Resident 30, and retained the one box of chemotherapy pills in the medication cart, and gave all the rest of the medications back to Resident 30's boyfriend. Resident 30 confirmed what LN 25 stated. LN 25 stated he was the one who reminded Resident 30 to call UCSD pharmacy about medication renewal when the cart was running low, and Resident 30 confirmed this as well. On 9/12/2025 at 2:38 P.M. an interview with the Director of Nursing (DON) 2 was conducted. DON 2 stated that LN 25 forgot to notify physician that Resident 30's chemotherapy medication was about to expire, and he should have. DON 2 stated the importance of notifying physicians when medication is about to expire to communicate resident's needs and prevent lapses in medication. The DON 2 stated that LN 25 should have filled out an inventory sheet for Resident 30's personal medication upon receipt to accurately account for Resident 30's medication and to prevent missing medication or diversion. DON 2 stated that LN 11 should have documented accurately in the MAR and progress note to provide clear communication that accurate medication administration occurred and to accurately account for Resident 30's personal medication. Review of facility policy titled Pharmacy Services, Medication Administration/med carts and Storage dated 3/2025, indicated It is the policy of this facility to accurately, prepare, administer, and document medications as per physician's orders. The facility to also ensure the proper and safe storage of drugs and biologicals. 8. All specialty medications from outside pharmacies or brought by family must have an account sheet to reflect number of medications received.		

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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** Based on observation, interview, and record review, the facility failed to properly store intravenous (IV-a plastic tubing inserted through the vein) supplies for one of 21 residents (Resident 42) when an opened IV flush syringe (device used to inject fluids a water solution through an IV that prevents clogs) and a green IV cap cover was left unattended and stored improperly. This deficient practice placed Resident 42 at risk for contamination, infection and unsafe administration of IV medications and supplies. Findings: A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included history of Irritable Bowel Syndrome (IBS-uncomfortable or painful abdominal symptoms). A record review of Resident 42's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/10/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 42 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 10:13 A.M., an observation and interview was conducted with Resident 42, in Resident 42's room. Resident 42 was lying in bed in an upright position with an IV medication flowing to her left (L) lower arm. Resident 42's dresser had her gray purse with an opened IV flush and a green IV cap cover left unattended. On 9/9/2025 at 10:53 A.M., an observation and interview with Director of Nursing (DON) 1 was conducted, in Resident 42's room. DON 1 stated she was the only Registered Nurse (RN) on the floor at that time and was the IV nurse responsible for administration of IV medications. DON 1 observed Resident 42's dresser and on top of the dresser was an unattended opened IV flush with a green IV cap cover. DON 1 stated this should not be here and picked up the unattended IV supplies. DON 1 stated this was a safety issue because Resident 42's line if used could get contaminated causing an infection and/or inappropriately used by someone else to cause a safety issue if used incorrectly. DON 1 stated the IV supplies need to be stored properly in the IV cart and locked when unattended. A review of the facility's policy and procedure titled, Medication Administration/Med cart and Storage Revised 3/2025, indicated . Drugs and/or biologicals should not be left unsecured/unattended. Drug deliveries should be stored immediately after delivery and should not be left unattended/unsecured.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly store and dispose of refuse (trash, garbage or rubbish) in a sanitary manner when the outside dumpster lids were opened and accessible to pests. This deficient practice placed all 69 residents at risk for pest infestation, foul odors, and the spread of infection. Findings: On 9/10/2025 at 8:48 A.M., an observation and interview was conducted with the Dietary Supervisor (DS), outside of the kitchen back exit. There was two dumpsters outside with one dumpster's lid open. The opened dumpster contained garbage in clear plastic bags and cardboard boxes scattered in the dumpster with a foul odor coming out from the dumpster. The DS stated the dumpster lids needed to be closed to contain the garbage that was inside the dumpster and to prevent pests such as rats, and flies from entering the dumpster and potentially spreading infection. A review of the facility's policy and procedure titled, Miscellaneous Areas dated 2023, indicated . Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed .		

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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** Based on interview and record review, the facility failed to ensure resident's belongings were documented in the medical record for one of three sampled residents (24).As a result, there was no way to verify where Resident's 24 belongings went. Findings:Per the facility's admission Record, Resident 24 was admitted to the facility on [DATE] with diagnoses to include generalized anxiety (worry) disorder.On 9/10/25 a review was conducted of Resident 24's medical record. There were no progress notes documenting the incident, and there were no progress notes of any kind documented on 9/6/25.On 9/9/25 at 2:44 P.M., an interview was conducted with Resident 24. Resident 24 stated, she had vitamins in her room which went missing. Resident 24 further stated, she told the administrator and other facility staff about her missing vitamins but they told her they couldn't find them and didn't do anything to help her.On 9/12/25 at 9:16 A.M., an interview was conducted with the Social Worker (SW). The SW stated, they took Resident 24's vitamins because she was not allowed to store them in her room. The SW further stated, she did not remember if anyone from nursing was involved in the process of taking Resident 24's vitamins. The SW stated she did not document anything regarding the incident.On 9/12/25 at 9:20 A.M., an interview was conducted with Director of Nursing (DON) 1. DON 1 stated, there was no documentation regarding the taking of Resident 24's vitamins. DON 1 further stated, when Resident 24's vitamins were taken, the facility should have documented the incident and what was done.The facility was unable to provide a policy on documentation.		

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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 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 infection control practices for one of 21 residents sampled (Resident 100) when a Certified Nursing Assistant (CNA) provided mouth care without wearing a gown for a resident on Enhanced Barrier Precautions (EBP-infection control precautions to reduce transmission of multi-drug resistant organisms (MDRO) a bacteria that resists treatment with more than one antibiotic).These deficient practices placed all 21 residents at risk for the spread of infection and cross-contamination.Findings:A review of Resident 100's admission Record indicated Resident 100 was re-admitted to the facility on [DATE] with diagnoses which included history of Malignant Neoplasm of Prostate (prostate cancer- an abnormal tumor located below the bladder in males).A record review of Resident 100's minimum data set (MDS - a federally mandated resident assessment tool) dated 5/31/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 100 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/9/2025 at 12:25 P.M., a record review was conducted on Resident 100's clinical chart. Resident 100's care plans and physician (MD) active orders included:- Care plan initiated 9/9/25 indicated, .Requires Tube feeding (TF-soft, flexible plastic tubes through which liquid nutrition travel through the stomach) .Use Enhanced Barrier Precautions [EBP].- MD orders dated 9/9/25 indicated, .ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: Indwelling [a medical device or tube that is designed to be left inside the body for access and exchange of fluid and/or drainage] medical devices, and or history of infection or MDRO status every shift for G-tube [gastrointestinal tube: a flexible tube through an opening in the stomach] . On 9/11/2025 at 8:29 A.M., an observation and interview was conducted with Resident 100, in Resident 100's room. Resident 100 was in an upright position in bed with his TF turned off and TF disconnected from the TF machine. Resident 100 had a Certified Nursing Assistant (CNA) as a sitter at his bedside while CNA 1 bagged Resident 100's soiled clothing and linens in a plastic bag then left Resident 100's room to dispose of the dirty linens and clothing. Resident 100 was unable to carry on a conversation if he ate that morning and stated, I think I'm on my final encounter.On 9/11/2025 8:33 A.M., an observation was conducted in Resident 100's room. CNA 1 returned to Resident 100's room and put on gloves after using an alcohol-based hand rub (ABHR) then proceeded to provide mouth care on Resident 100 with a wet towel without wearing personal protective equipment (PPE: such as gowns, gloves, masks, and eye shields) gown then left Resident 100's room.On 9/11/2025 at 8:37 A.M., an interview was conducted with CNA 2. CNA 2 stated CNA 1 was providing mouth care to Resident 100 without wearing a gown while providing direct contact care. CNA 2 stated it was important to wear proper PPE with gown and gloves while providing direct contact care for Resident 100 to prevent the spread of infection because Resident 100 was on EBP as stated outside of Resident 100's room with an EBP sign and PPE's stored inside the plastic cabinet.On 9/12/2025 at 9:26 A.M., an interview was conducted with the Infection Prevention Nurse (IPN). The IPN stated Resident 100 was on EBP because he was immunocompromised (weakened immune system to fight off illness) due to Prostate Cancer and a history of MDRO. The IPN stated Resident 100 also had a TF being delivered through the G-tube which was also a high risk for infection because it was an open wound. The IPN stated CNA 1 should have worn proper PPE (gown and gloves) while providing mouth care because this was considered high contact direct care to prevent the spread of infection.On 9/12/2025 at 11:31 A.M., an interview with Director of Nursing (DON) 1 was conducted. DON 1 stated it was her expectations with the nursing staff when providing direct contact care such as providing mouth care with Resident 100 who was on EBP (history of MDRO and cancer) to be wearing the proper PPEs (gown and gloves). DON 1 stated CNA 1 should have worn a gown while providing mouth care to Resident 100 to reduce the transmission of infection (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Palomar Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to protect both the residents and staff.A review of the facility's policy and procedure titled, IPCP Standard and Transmission-Based Precautions Revised 1/2025, indicated .Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube .regardless of MDRO colonization status.During high-contact resident care activities.providing hygiene.		