STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Escondido Post Acute Rehab	421 E Mission Ave 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 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** 39220 Based on interview and record review, the facility failed to develop person-centered care plans for one of five residents (Resident 1), related to: a. The potential for falls; b. Pain; c. Urinary tract infection (UTI-an infection in the urine); d. Anticoagulant (blood thinning medication) therapy; and e. The potential for skin injuries. As a result, there was the potential Resident 1's care was not being provided consistently and potential problem areas were not identified. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included fall, resulting in a fracture to the right hip and right wrist, requiring surgical aftercare, per the facility Admission Record. On 7/18/24, Resident 1's clinical record was reviewed: a. (Falls) According to the facility's Fall Risk Assessment, dated 7/2/24, Resident 1 had a fall assessment score of 22, scores 16-42 indicate High Risk for falls. According to the 5-day Minimum Data Set (MDS-a clinical assessment tool), dated 7/8/24, Resident 1 had one fall prior to admission, resulting in an injury, requiring surgery. There was no documented evidence a care plan was developed or implemented for risk of future falls. (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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NAME OF PROVIDER OR SUPPLIER Escondido Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 421 E Mission Ave Escondido, CA 92025	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. (Pain)- According to the physician's order, dated 7/2/24, Methadone (an opioid used for chronic pain), 7.4 milliliters (ml) one time a day by mouth for pain, Oxycodone (a pain medication), 10 milligrams (mg) every 4 hours as needed for severe pain, Oxycodone 5 mg by mouth every four hours as needed for moderate pain. Acetaminophen (Tylenol) 325 mg, give 2 tablets by mouth every 4 hours as needed for mild pain. According to the facility's Admission Pain Assessment, dated 7/2/24, Resident 1 complained of pain with movement and listed current pain scores of 4-8 (0 indicates no pain, and 10 indicates worst pain). According to the 5-day MDS, dated [DATE], Resident 1 was experiencing pain almost constantly. There was no documented evidence a care plan had been developed or implemented to address pain. c. (UTI) According to the physician's order, dated 7/2/24, give Cephalexin (an antibiotic used to treat bacterial infections) by mouth four times a day for UTI (urinary tract infection) for 5 days. There was no documented evidence a care plan had been developed or implemented urinary traction infection or antibiotic therapy. d. (Anticoagulant)- According to the physician's order, dated 7/2/24, Heparin (a medication used to prevent blood clots) injection 5000 units/ml, inject 1 ml subcutaneously (administered in a fatty part of the body) two times a day foe DVT (deep vein thrombosis-blood clots that can develop in the legs), give only in the abdomen, rotate sites. There was no documented evidence a care plan had been developed or implemented for anticoagulant therapy. e. (Skin) According to the physician's order, dated 7/2/24, .Braden scale (a standardized tool used by healthcare providers to determine a resident's risk for developing pressure ulcers [pressure related skin injuries], every week .Monitor right wrist for skin breakdown every shift . According to the Braden Scale Assessment, dated 7/2/24, Resident 1 had an assessment score of 16, indicating the resident was at a high risk for skin injury. The Admission Assessment, section L: Skin Evaluation dated 7/2/24, documented bruising on the right hand, right hip, surgical incision (total of 11 staples) to the right femur (upper thigh bone), and right hip. According to the 5-day MDS, dated [DATE], Resident 1 was identified as having surgical wounds and was provided a pressure reducing device for the bed. There was no documented evidence a care plan for potential for skin injuries or for surgical wounds was developed or implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 11:13 A.M., an interview was conducted with the Treatment Nurse (Tx LN). The Tx LN stated Resident 1 had surgical wounds which she cleaned daily and inspected for signs of infection. The Tx LN stated a care plan for the surgical wounds should have been developed on admission for Resident 1, because Resident 1 was at risk for developing skin injuries from immobility due to her fractures. The Tx LN stated the care plan should also list what treatment was being provided for the surgical wounds, and she had not done this. On 7/18/24 at 11:56 A.M., an interview was conducted with Licensed Nurse 2 (LN 2). LN 2 stated if Resident 1 was admitted with a UTI and was on antibiotics, a care plan should have been developed, such as staff to encourage fluids and watch for worsening UTI symptoms. LN 2 stated care plans were important for staff to provide consistent care for current problems and to recognize the potential for other developing problems. On 7/18/24 at 12:04 P.M., an interview was conducted with the Director of Nursing (DSD). The DSD stated Resident 1's care areas should have been identified on care plans, so staff were aware of the issues and provide consistent care. On 7/18/24 at 12:40 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON), since the Director of Nursing was unavailable. The ADON stated care plans were important to identify risk or actual problems and to ensure staff were consistently providing the interventions listed on the care plan. The ADON reviewed Resident 1's current care plans, which consisted of bed mobility, nutrition, and Activities of Daily Living (ADL). The ADON stated she did not see care plans, for skin, falls, UTI, anticoagulant therapy, or pain and they should have been captured as base line and they were not. The ADON stated she expected the admission nurse to develop baseline care plans and then the Minimum Data Set Nurse would follow up to ensure proper care plans were developed. According to the facility's policy, titled Care Plans-Baseline, dated March 2022, .1. The .care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to perform and document skin assessments prior to a discharge for one of five residents (Resident 1), reviewed for services meeting professional standards of practice. As a result, Resident 1 was discharged , and family were unaware of the bruises and skin injuries caused while at the facility. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included fall, resulting in a fracture to the right hip and right wrist, requiring surgical aftercare, per the facility Admission Record. On 7/18/24, an unannounced visit was made to the facility in response to a complaint. The complainant provided two photographs of Resident 1's lower abdomen (lower stomach) area, showing numerous areas of black/blue/green/yellow bruising. On 7/18/24, Resident 1's clinical record was reviewed: According to the physician's order, dated 7/2/24, .Braden scale (a standardized tool used by healthcare providers to determine a resident's risk for developing pressure ulcers [pressure related skin injuries], every week .Monitor for signs and symptoms of bleeding/bruising (on anticoagulant-a blood thinner medication), every shift .Heparin [blood thinner] 5000 units, two times a day, subcutaneous [injection in the fatty part of body], give only in the abdomen .Tx [treatment] for surgical sites at right thigh with 11 staples .ever day shift . According to the Braden Scale Assessment, dated 7/2/24, Resident 1 had an assessment score of 16, indicating the resident was at a high risk for skin injury. The Admission Assessment, Skin Evaluation dated 7/2/24, section documented bruising on the right hand, right hip, surgical incision to the right femur (upper thigh bone), and right hip. No other bruising was documented. According to the shower sheets, Resident 1 refused a shower on 7/3/24 and agreed to a shower on 7/6/24. The certified nursing assistant (CNA), did not document on the 7/6/24 shower sheet, the right hip staples, or any bruising or skin injuries, but documented Resident 1 complained of backpain in the tailbone. According to the Medication Administration Records (MAR), from 7/2/24 through 7/8/24 (patient- initiated discharge) Nursing staff consistently documented no for bruising due to anticoagulant therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Discharge Summary, dated 7/8/24, Licensed Nurse 1 (LN 1) documented under section E: Skin Condition Upon Discharge Monitor surgical incision on right hip for sign & symptoms of complications. Notify MD (medical doctor) if noted. Splint on right hand at all times except during hygiene. There was no documented evidence of any bruises or skin injuries. On 7/18/24 at 11:13 A.M., an interview was conducted with the Treatment Nurse (Tx LN). The Tx LN stated she independently remembered Resident 1, because she had staples to her right hip and leg. The Tx LN stated she checked the wound daily and cleaned it with betadine (an antiseptic solution that provides infection protection). The Tx LN stated she did not provide any other skin treatment and usually performed full skin exams weekly, but Resident 1 was discharged before the week was up. On 7/18/24 at 11:56 A.M., an interview was conducted with LN 2. LN 2 stated she routinely performed resident discharges. LN 2 stated full head to toe examinations were required by the LN discharging the resident, to identify skin injuries, bruises, or potential problems. LN 2 stated if skin assessment were not performed at the time of discharge, the resident could be going home with an unidentified wound infection or skin injury and the family was not educated on what to watch for or how to treat. LN 2 stated it was a nursing standard of practice to perform skin assessments on admission, during showers, weekly, and when resident's were discharged from the facility. On 7/18/24 at 12:04 P.M., an interview was conducted with the Director of Staff Services (DSD). The DSD stated skin assessments when residents were discharged from the facility were important, so the facility was aware of the resident's skin condition at the time of discharge. The DSD stated skin assessments were performed by all staff during any resident care that was performed. The DSD stated continuous skin assessments and skin care was a standard of practice, to ensure quality of care was being provided. The interview with the DSD was continued. Resident 1's shower sheet for 7/6/24 was reviewed. The DSD stated the CNA who provided the 7/6/24 shower was from a registry agency. The DSD stated the shower sheet was not completed correctly because Resident 1's hip and leg staples, along with her surgical sites were not identified or documented. The DSD stated if Resident 1 was receiving heparin injections in the abdomen, Resident 1 could of had bruising in the abdomen. On 7/18/24 at 12:30 P.M. an interview and record review was conducted with LN 1, regarding the discharge summary document she completed on 7/8/24. LN 1 could not independently remember Resident 1, but was able to recall the resident after viewing the electronic clinical record. LN 1 stated the Case Manager informed LN 1 that Resident 1 needed to be discharged right away. LN 1 stated it was very busy at the time and the discharge was last minute, so she was unable to perform a head-to-toe assessment, like she normally does. LN 1 stated she was rushed to discharge Resident 1 home with her family, and she did not check the resident's skin for potential injuries. LN 1 stated if Resident 1 was receiving heparin injections in the abdomen, Resident 1 most likely would have bruising in that area. On 7/18/24 at 12:40 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON), since the Director of Nursing was unavailable. The ADON reviewed Resident 1's shower sheet from 7/6/24 and the Discharge Summary completed by LN 1. The ADON stated the shower sheet should indicate Resident 1's surgical wounds and staples and it did not. The ADON stated skin assessments should always be completed on discharge and documented. The ADON stated the discharge skin assessments should capture potential skin issues and the family would need to be educated on what to watch out for and when to call the physician. The ADON stated it was a standard of nursing practice to perform skin assessments on admission, throughout the resident's stay, and on discharge, to identify problems early. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON stated the facility uses the DMS [NAME] for nursing standards or practice.