STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056040	A. Building B. Wing	10/08/2024

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** 46982 Based on observation, interview, and record review the facility did not implement interventions to prevent a fall for one of three residents (Resident 1) reviewed for a fall. This failure increased the risk of injury related to falls for Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with diagnosis that included: epilepsy (a brain condition of abnormal electric impulses that cause seizures, which can be staring, jerky movements, body stiffness, loss of consciousness); unsteady on feet; A BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) test, completed on 7/22/24 noted Resident 1 with a score of 6, severely impaired. On 8/28/24 at 3:40 P.M. A family member was interviewed. The family member (FM) reports Resident 1 had a fall a few days ago, in addition to a fall outside the facility that happened mid-July, when Resident 1 was sent to the hospital. FM 1 stated Resident 1 hurt himself pretty bad in July. The family member said she was notified of the fall in July by the hospital staff and called the skilled nursing facility right away. On 8/28/24 at 3:46 P.M. Certified Nurse Aide (CNA) 1 entered the room . CNA 1 checked the fall alarm on Resident I ' s bed and stated, the battery is dead. On 8/29/24 at 9:40 A.M. Resident 1 was observed to be in the bathroom and CNA 1 was in Resident 1 ' s bedroom. Resident 1 self-transferred to the wheelchair, without locking the brakes, and propelled himself to the bed. CNA 1 stated Resident 1 does that (transfers self) a lot and it ' s ok. Resident 1 ' s bed was observed to be in a standard, not low position. CNA 1 said he does check on the resident frequently to see if he needs anything, but not on a schedule. On 8/29/24 at 9:56 A.M. LN 2 was interviewed. LN 2 stated Resident 1 was very unsteady, and a fall risk. LN 2 stated Resident 1 needs one person to assist with transfers and with ambulation (in the wheelchair). He (Resident 1) does not remember to ask for help, he wants to be independent, but he is confused. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 2:39 P.M. CNA 6 was interviewed. CNA 6 stated Resident 1 is incontinent but always wants to go to the bathroom and with eleven other patients to take care of it can be difficult. CNA 6 stated, Resident 1 will be up and down most of the evening, trying to get out of bed and Resident 1 falls often. CNA 6 stated routine toileting on a schedule is not offered to Resident 1. On 8/29/24 Resident 1 ' s record was reviewed: Per Resident 1 ' s care plan dated 8/29/24, Focus, Falls: Resident had an unwitnessed fall and is at risk for recurring falls. Date initiated 07/17/2024. Goal will minimize risk for additional falls to the extent possible. Date initiated: 07/17/2024. Target Date 11/10/24. Interventions/Tasks: Keep bed in low position .07/17/2024, Provide verbal reminders/cues to ask for assistance as needed Date initiated: 07/17/2024. Resident 1 ' s IDT note dated 8/26/24 recommends staff redirect resident to his room and assist with toileting every 2-3 hours .prompted toileting every three hours. Resident 1 ' s Progress Note New Effective Date 08/26/2024 16:19 Type: IDT Fall. Current Interventions: Redirect resident into his room. Assist with toileting q 2-3 hours.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982 Based on observation, interview, and record review the facility did not implement interventions to prevent a fall for one of three residents (Resident 1) reviewed for a fall. This failure increased the risk of injury related to falls for Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with diagnosis that included: epilepsy (a brain condition of abnormal electric impulses that cause seizures, which can be staring, jerky movements, body stiffness, loss of consciousness); unsteady on feet; A BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) test, completed on [DATE] noted Resident 1 with a score of 6, severely impaired. On [DATE] at 3:40 P.M. A family member was interviewed. The family member (FM) reports Resident 1 had a fall a few days ago, in addition to a fall outside the facility that happened mid-July, when Resident 1 was sent to the hospital. FM 1 stated Resident 1 hurt himself pretty bad in July. The family member said she was notified of the fall in July by the hospital staff and called the skilled nursing facility right away. On [DATE] at 3:46 P.M. Certified Nurse Aide (CNA) 1 entered the room . CNA 1 checked the fall alarm on Resident I ' s bed and stated, the battery is dead. On [DATE] at 9:40 A.M. Resident 1 was observed to be in the bathroom and CNA 1 was in Resident 1 ' s bedroom. Resident 1 self-transferred to the wheelchair, without locking the brakes, and propelled himself to the bed. CNA 1 stated Resident 1 does that (transfers self) a lot and it ' s ok. Resident 1 ' s bed was observed to be in a standard, not low position. CNA 1 said he does check on the resident frequently to see if he needs anything, but not on a schedule. On [DATE] at 9:56 A.M. LN 2 was interviewed. LN 2 stated Resident 1 was very unsteady, and a fall risk. LN 2 stated Resident 1 needs one person to assist with transfers and with ambulation (in the wheelchair). He (Resident 1) does not remember to ask for help, he wants to be independent, but he is confused. On [DATE] at 2:39 P.M. CNA 6 was interviewed. CNA 6 stated Resident 1 is incontinent but always wants to go to the bathroom and with eleven other patients to take care of it can be difficult. CNA 6 stated, Resident 1 will be up and down most of the evening, trying to get out of bed and Resident 1 falls often. CNA 6 stated routine toileting on a schedule is not offered to Resident 1. On [DATE] Resident 1 ' s record was reviewed: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per Resident 1 ' s care plan dated [DATE], Focus, Falls: Resident had an unwitnessed fall and is at risk for recurring falls. Date initiated [DATE]. Goal will minimize risk for additional falls to the extent possible. Date initiated: [DATE]. Target Date [DATE]. Interventions/Tasks: Keep bed in low position XXX[DATE], Provide verbal reminders/cues to ask for assistance as needed Date initiated: [DATE]. Resident 1 ' s IDT note dated [DATE] recommends staff redirect resident to his room and assist with toileting every ,d+[DATE] hours .prompted toileting every three hours. Resident 1 ' s Progress Note New Effective Date [DATE] 16:19 Type: IDT Fall. Current Interventions: Redirect resident into his room. Assist with toileting q ,d+[DATE] hours. Based on observation, interview and record review, the facility failed to implement their plan of care and elopement (unsafe and unsupervised leaving the facility without staff knowledge) policy and procedure for one of three sampled residents, Resident 1. This failure had the potential to place Resident 1 at risk for future elopment and other residents identified to be at risk for elopement. Findings: Resident 1 was admitted to the facility on [DATE] with diagnosis that included: Diabetes (a condition that occurs when the body cannot regulate blood sugar levels) with a foot ulcer (a would that is a complication of diabetes); epilepsy (a brain condition of abnormal electric impulses that cause seizures, which can be staring, jerky movements, body stiffness, loss of consciousness); unsteady on feet; acquired absence of right great toe (surgical amputation). A BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) test, completed on [DATE] noted Resident 1 with a score of 6, severely impaired. On [DATE] at 3:40 P.M. an observation and interview were held with Resident 1 and a family member. Resident 1 had a falling star symbol on the door frame. Resident 1 was up and seated in one of two wheelchairs (wheelchair 1) that were in the room. Wheelchair 2 was against the wall, with pillows and blankets on the seat. A wander guard device (a bracelet that is placed on a resident or their wheelchair to prevent wandering out of the facility without staff knowledge-the bracelet activates an alarm, and locks exit doors equipped to receive the signal) was on the back of wheelchair 2. On [DATE] at 3:46 P.M. Certified Nurse Aide (CNA) 1 entered the room, and CNA 1 verified there was no wander guard device on the wheelchair Resident 1 sat in. On [DATE] at 4:15 P.M. an observation and interview were held with the Director of Nursing (DON). The DON stated the wander guard on wheelchair 2 would be moved over to wheelchair 1 later this evening, after Resident 1 went to bed. On [DATE] at 4:45 P.M. Licensed Nurse (LN) 1 was interviewed. LN 1 stated Resident 1 uses his arms to propel self in the wheelchair. LN 1 stated Resident 1 was confused, but he gets in the wheelchair and just goes (fast). (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:40 an observation of Resident 1 and a concurrent interview with CNA 2 was held. The wander guard for Resident 1 had remained on wheelchair 2, and Resident 1 is still seated in wheelchair 1. Beginning on [DATE], facility records for Resident 1 were reviewed. An SBAR Communication Form (used by facility to document unusual occurrences) dated [DATE] noted Resident (1) was seen by a licensed nurse from a distance wheeling himself on the sidewalk and immediately run [sic] after the resident, by the time the nurse caught up with the resident, resident had fallen on the sidewalk, noted with skin tear on left forearm and bump on the left side of his forehead. Resident was picked up via 911 en route to the nearest ED. According to the SBAR, the MD was informed at 5:00 P.M. on [DATE] and (name) RN, VA Case Manager was notified on [DATE] at 4:50 P.M. (Spouse) of Resident 1 is listed, without a time listed. An IDT (Interdisciplinary Team-group of staff) note dated [DATE] as a late entry for [DATE] reflected Resident 1 returned from the hospital after a few hours, and the following was recommended after discussion with spouse: Place an identifier on door for staff awareness of risk for elopement; Add (Resident 1 ' s) photo to the list at the front desk for risk of elopement; Risk of Elopement binders for all nursing stations; Continue Certified Nursing Assistant (CNA) monitoring sign on for any risk of elopement assigned . Physician ' s Order Listing for Resident 1 included an order, dated [DATE], for Wanderguard check placement every shift. The care plan, dated [DATE] and titled Elopement included: .Monitor whereabouts frequently. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2 ' s diagnoses included: Dementia (a disorder of decline of brain function, leading to a loss of memory, attention, and thinking skills that interfere with daily life); muscle weakness; abnormal posture; history of falling. Resident 2 ' s BIMS (Brief Interview of Mental Status- a test for memory and thinking skills) dated [DATE] was 11, which reflects moderate impairment in mental functioning. On [DATE] at 9:25 A.M. Resident 2 was observed sitting in a wheelchair in the hallway, with a chair alarm in place. Resident 2 is dressed in a jacket, shirt, and pajama bottoms, with non-skid socks on his feet. A wander guard bracelet is on Resident 2 ' s right ankle. Physician ' s Order Listing for Resident 2 included an order, dated [DATE], for Wonder [sic] Guard for attempted elopement every shift for safety. On [DATE] at 9:56 A.M. an interview was held with LN 2. LN 2 stated the yellow sign on the doorway marked E was for electrical equipment in the room, like feeding tubes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:18 A.M. an interview was held with LN 3. LN 3 correctly stated the yellow sign marked E was to identify residents at high risk for wandering. LN 3 stated, staff checks on these residents frequently to know where they are. LN 3 stated If the resident has a wander guard, we check the book to see if the wander guard is expired. The book is yellow, to match the door symbol, and is kept at each nursing station. On [DATE] at 10:24 A.M. the facility's Elopement Binder at nursing station 2 was reviewed. Page 1 is a Master List of all residents in the facility that are high risk for elopement and followed by photos of the residents for that station. A total of 19 residents were listed on the Master List. The Master list also included the expiration date of each Wander Guard, and where it was located for each resident (arm, ankle, wheelchair, walker, etc.). Behind the Master List are blank tracking sheets, titled Risk for Elopement with columns for each Resident Name, and each work shift (AM, PM, NOC-Night) labeled. Each shift is broken down into 2-hour increments. AM shift is 7 A.M. to 3 P.M. PM shift is 3 P.M. to 11 P.M. and NOC (Night) shift is 11 P.M. to 7 A.M. Dividers numbered ,d+[DATE] are behind the blank flowsheets. On [DATE] the facilities elopement records were reviewed. In the binder at station 2, Risk For Elopement (tracking sheets) are located dated [DATE], [DATE], [DATE], and [DATE].The tracking sheet dated [DATE] had five of seven residents listed from the master list, and the A.M. section for whereabouts and CNA signatures was completed for A.M. shift only. On the tracking sheet dated [DATE], the flowsheet was completed for six out of the seven residents, for the A.M. shift only. On the tracking sheet dated [DATE], four of seven residents were listed, and completed for the A.M. shift only. On the tracking sheet dated [DATE], only one resident was listed, and the initials and resident whereabouts for this resident were completed through 3 P. M. On [DATE] at 10:26 A.M. LN 3 was interviewed again. LN 3 stated the CNA ' s are responsible for the charting on the tracking sheets, and (the LN ' s) are responsible for ensuring the tracking sheets are completed and the monitoring is done. LN 3 confirmed the list of seven residents at risk for elopement for station 2 was correct and current. LN 3 stated it is expected the documentation will be done each day. LN 3 also stated documentation should never be done ahead of time. On [DATE] at 12:38 P.M. the eMAR (Medication Administration Record-a document where the licensed nurse initials for medications and monitoring for a resident was completed) for Resident 1 for July and August was reviewed. The eMAR reflected LN initials in each space for every shift to document the presence of a wander guard, beginning with [DATE]. On [DATE] at 10:30 A.M. the station 3 Elopement Binder was reviewed along with the log pages for [DATE] - 31 2024 for all of the binders. The station 3 Elopement Binder contained seven pages, dated ,d+[DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. On ,d+[DATE] seven residents were listed with no monitoring. The remaining six sheets were incomplete, not all the residents listed or not all the shifts had charted resident whereabouts. The requested documentation of the Risk for Elopement wandering sheets from [DATE] through [DATE] were not provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] record review of Policy and Procedure dated [DATE] for Elopements was reviewed, the policy did not describe procedures to identify residents at risk for elopements and strategies to minimize those risks. On [DATE] another policy, undated, titled Wandering and Elopements was provided and reviewed. Per the policy, under Policy Interpretation and Implementation the policy noted: .4. When the resident returns to the facility, the directr [sic] of nursing services / designee or charge nurse shall: .g. place the E yellow door identifier on the resident ' s door. h. Update the elopement binder at the nurse ' s station and reception desk to reflect the resident ' s name and inform the staff to monitor and sign the monitoring record in the binder each shift.RNA will check for good function of the wander guards every week.