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	12/20/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982 Based on observation and interview, the facility failed to treat one of seven sampled residents with dignity and respect. This failure had the potential for Resident 6 to feel ashamed and embarassed. Findings: Resident 6 was admitted to the facility on [DATE]. Resident 6's health conditions included: dementia; malignant neoplasm (spreading cancer) of the stomach according to her Admission Record. On 11/22/24 at 10:56 A.M. an observation and interview were held with Resident 6 in her room. Resident 6, a small lady, was seen sitting up in bed, propped up with pillows, leaning to the left. Resident 6's breakfast tray was still in front of her. Oatmeal was seen on her lower face, and dripping from her chin onto her bedding. Resident 6 was wearing a hospital gown, unsnapped at the right collar. Her right collar bone, upper ribs and breastbone were visible. A bath blanket was sideways over her, exposing her lower legs and her right thigh. On 11/22/24 at 11:02 A.M. Licensed Vocational Nurse (LN) 1 responded to Resident 6's call light, and asked Resident 6 if she needed anything. Resident 6 did not verbally respond. LN 1 said she would get staff and left the room. On 11/22/24 at 11:10 A.M. LN 1 returned to Resident 6's room with Certified Nursing Assistant (CNA) 1. Together CNA 1 and LN 1 performed a bed bath and complete linen change for Resident 6, with a brief and gown change as well. Staff were silent during the time, except for a direction to Resident 6 to turn this way from LN 1. CNA 1 and LN 1 assisted Resident 6 into a yellow brief, which seemed too big- the tab ends crossed each other in the front. CNA 1 stated the brief was size extra-large, and Resident 6 should wear a small or medium. CNA 1 stated this was the size available. Resident 6 was covered with a top sheet and staff left the room. On 11/22/24 at 11:35 Resident 6 spontaneously stated she feels better but does not answer any questions. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 11:40 LN 1 was interviewed. LN 1 stated breakfast is served between 7:15 and 7:45 A.M. LN 1 stated Resident 6 is deaf, and cannot hear what is said to her. Usually, staff talks to residents as we are giving care . LN 1 stated too large of a brief could cause leaks, a wet bedding, clothing, could cause skin breakdown, and chafing or rubbing of skin where it didn't fit well. LN 1 said she would check on a smaller brief for Resident 6.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46982 Based on observation, interview and record review, the facility failed to exercise care in protecting 1 residents' (Resident 2) property from loss and physical damage out of 11 property loss reports reviewed. As a result, the resident's painting was reported lost. Resident 2 was admitted to the facility on [DATE] with health conditions including osteomyelitis (infection of the bone) right tibia and fibula (lower leg bones); diabetes type 2 (a chronic disease of the body not producing insulin, causing high blood sugars). Resident 2 was transferred from the facility to an Acute Care Hospital (ACH) due to a new cough, with difficulty breathing and a need for oxygen on 11/1/24 at 4:50 P.M., according to the SBAR communication form dated 11/1/24. On 11/25/24 at 4:30 P.M. the Director of Social Services (DSS) was interviewed in her office, and Resident 2's chart was reviewed, along with the past seven months of missing property reports. The DSS stated there had been 11 missing property reports filed, with 1 report which indicated the item was found; and 5 reports which indicated facility had replaced the missing items. The DSS stated the painting was reported missing on 11/6/24 by the daughter when she came to the facility to pick up Resident 2's belongings. The daughter also stated Resident 2's belongings were improperly stored in a utility room, accessed from outside. The DSS is not sure where discharged resident belongings are kept while waiting for the items to be picked up. The DSS stated storage used to be in the office next door, but that was full, and with the remodel the DSS was not sure what other spaces were available. On 11/25/24 at 4:50 P.M. the Central Supply Person (CSP) was interviewed. The CSP stated he initially located Resident 2's belongings outside, on the back patio, contained in two 14x48 inch bags. The CSP stated there were some paintings near the bags, and they were thrown away due to rain damage. The CSP could not state the reason Resident 2's bags and the paintings were left outside. The CSP stated he moved the bags to a covered storage area. The CSP remembers when Resident 2's family came he assisted them by showing where the bags were stored, because the bags had ripped open as he lifted the bags for the family. The CSP stated storage for resident belongings is wherever you can find room due to the recent remodel. On 11/26/24 at 2:50 P.M. LN 6 was interviewed. LN 6 stated after a resident is discharged , any belongings are packed up by the Certified Nursing Assistant (CNA), and housekeeping staff (HK) pack and label all belongings to place in a storeroom for pick up. LN 6 did not know where the storeroom was located. On 11/26/24 at 3:05 P.M. LN 7 was interviewed. LN 7 stated when residents go out quickly, nursing staff will pack up belongings and housekeeping stores them. LN 7 is not sure where the resident's belongings are kept while waiting for pick up. On 11/26/24 at 4:45 P.M. LN 8 was interviewed. LN 8 stated resident belongings are packed by nursing staff if needed, and placed in a storage area (gestures to a room around the corner) for the family to pick up later. Only staff is allowed access. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 3:31 P.M. a joint interview was held with the Administrator (ADM) and the Director of Nursing (DON). The ADM stated resident belongings kept outside is not in accordance with their policy and procedure; they should be stored in a designated and secured space in the building. The DON stated after the initial search for an item, nursing staff is not involved with missing property investigations. On 11/25/24 the Policies for Personal Property and Lost and Found were reviewed. The policy Personal Property dated March 2021, stated: .2. Resident belongings are treated with respect by facility staff, regardless of perceived value.5. the resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. 6. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property. The policy Lost and Found dated January 2008, stated: . 2. Items left by discharged residents must be reported to the director of nursing services.6. Resident or family complaints of missing items must be reported to the director of nursing services.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982 Based on interview and record review, the facility failed to notify residents and their representatives of the facility bed hold policy for four of four residents reviewed for notifications regarding bed holds before or as soon as possible after transfer to hospital. This failure had the potential for psychological harm related to uncertainty if the resident could return when their condition improved. Findings: Resident 2 was admitted to the facility on [DATE] with health conditions including osteomyelitis (infection of the bone) of right tibia and fibula (lower leg bones); diabetes type 2 (a chronic disease of the body not producing insulin, causing high blood sugars), according to her Admission Record. Resident 2 was transferred from the facility to an Acute Care Hospital (ACH) due to a new cough with difficulty breathing and a new need for oxygen on 11/1/24 at 4:50 P.M., according to the SBAR communication form dated 11/1/24. On 11/13/24 at 2:26 P.M. family of Resident 2 stated Resident 2's room was not held as they believed it would be, for 10 days, and her room was packed and cleared without family permission or knowledge. Resident 3 was admitted on [DATE] with health conditions that included: Type 2 diabetes, osteomyelitis of ankle and foot; chronic kidney disease, and unspecified heart failure, per the Admission Record. Resident 3 was transferred to the hospital on 10/7/24 due to an unspecified change in level of consciousness, a new need for oxygen, and uncontrolled body jerks according to the nurses note dated 10/7/24 at 8:10 P.M. Resident 4 was admitted to the facility on [DATE] with health conditions including: dementia; chronic kidney disease; anemia, according to her Admission Record. Resident 4 was transferred to theER on [DATE] due to increased confusion with hallucinations, and an abnormal lab result, dated 10/18/24, indicating infection. Resident 5 was admitted to the facility on [DATE], with health conditions including dementia; chronic obstructive pulmonary disease (difficulty breathing due to lung disease). Resident 5 was transferred to theER on [DATE] due to increased confusion reported to the physician on 10/22/24. On 11/26/24 at 2:50 P.M., LN 6 was interviewed. LN 6 stated she is not sure who does the bed hold notice when a patient is sent out emergently. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/24 at 3:05 P.M., LN 7 was interviewed. LN 7 stated that either the medication nurse or the supervisor nurse can notify the family a resident is being sent out. LN 7 stated she tried to complete her own notifications for her residents. On 11/26/24 at 4:45 P.M., LN 8 was interviewed. LN 8 stated the bed hold is for seven days, and there is a consent form. Usually, the bed hold is reviewed by phone, and two nurses sign for a phone notification. LN 8 could not locate a bed hold form, either blank, or completed, in a resident chart. On 12/9/24 at 3:30 P.M. a joint interview was held with the Administrator (ADM), Director of Nursing (DON), and the Director of Medical Records (DMR). The ADM stated the notice of bed holds is given at the time of admission for all residents. The ADM and the DON reviewed the facility's policy Bed Hold and Returns , dated March 2022, and agreed they did not give the second bed-hold notice, at the time of the emergency transfers to the hospital, as their policy required. The DMR stated there are no bed hold notices in the records of the requested residents. The facility policy for Bed Holds and Returns , dated March 2022, was reviewed with the ADM, DON and DMR. The policy reflected: .1. All residents/representatives are provided written information regarding the facility bed-hold policies.at least twice: a. well in advance of any transfer (e.g. in the admission packet); and 2. At the time of transfer (or, if the transfer was an emergency, within 24 hours).