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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Escondido Post Acute	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. Based on observation, interview, and record review, the facility failed to provide privacy and dignity by covering a urinary catheter bag (a flexible tube that drains urine into a collection bag) for one of three resident's (Resident 1), when reviewed for Resident Rights. This failure had the potential for Resident 1 to be embarrassed and exposed with a urinary catheter collection bag. Findings: Resident 1 was admitted to the facility 2/14/25, with diagnosis which included displaced fracture of left hip and diabetes mellitus (abnormal blood sugar levels in the blood), per the facility's admission Record. The physician's order was reviewed on 6/11/25 at 11:13 A.M., dated 6/11/25, .External condom catheter (a device that collects urine from the bladder and directs it into a collection bag) due to a diagnosis urinary retention (the inability to completely empty the bladder of urine) . An observation and interview was conducted with certified nursing assistant 1 (CNA 1) of Resident 1 on 6/11/25 at 12:08 P.M., as he laid in bed. On the lower right side of the bed frame was a urinary collection bag, which contained approximate 200 cubic centimeter (cc-a unit of volume) of yellow urine . The collection bag was uncovered and visible to all who entered the room. CNA 1 stated the urinary collection bag was not covered and it should be. CNA 1 stated a dignity bag over the collection bag provided the resident with privacy and promoted dignity. An interview was conducted with the Director of Staff Development (DSD) on 6/11/25 at 12:14 P.M. The DSD stated all residents with urinary catheters should have a dignity bag placed over the collection bag. The DSD stated it provided dignity to the resident, and it would not matter if the resident was alert or not. An interview was conducted with the Director of Nursing (DON) on 6/11/25 at 12:53 P.M. The DON stated dignity bags should always be covering a urinary collection bag, in order to provide privacy for the resident. According to the facility's policy, titled Dignity, dated 2001, .11. Staff promote, maintain, and protect privacy .

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to notify the physician when parameters for blood sugar levels were out of range, for one of three residents (Resident 1), when reviewed for Quality of Care. This failure resulted in the physician being uninformed when additional insulin (a hormone which regulates blood sugar levels in the blood) could have been ordered to reduce the risk of hyperglycemia (high blood sugar levels which can lead to health problems that affect the eyes, kidneys, nerves and heart). Findings: Resident 1 was initially admitted to the facility 2/14/25, with diagnosis which included displaced fracture of left hip and diabetes mellitus (abnormal blood sugar levels in the blood), per the facility's admission Record. Resident 1's record was reviewed on 6/11/25. Resident 1's nurses note, dated 6/6/25 at 8:48 P.M., Resident 1 was noted with confusion, doctor notified and new order to send to emergency room for evaluation. According to Resident 1's nurses note dated 6/9/25 at 11:15 P.M., resident returned from hospital with diagnoses of hyperglycemia (high blood sugar). According to Resident 1's physician's order, dated 6/10/25, Accu-Chek (a machine that analysis blood sugar levels with a drop of blood) call medical doctor if blood sugar is below 70 and/or above 250. According to Resident 1's Medication Administration Record (MAR), Resident 1's blood sugar level was 343 at 7 A.M. There was no documented evidence in Resident 1's nursing progress notes, that the medical doctor was notified of Resident 1's blood sugar level which was documented at 343 on 6/11/25, or that any new orders for insulin were obtained. According to Resident 1's care plan, titled Diabetes, revised on 4/14/25, interventions included, Blood sugar checks as ordered. Report to physician if blood glucose is outside of set parameters. According to Resident 1's care plan, titled Refusing Insulin, dated 5/23/25, no interventions were listed for addressing the resident's refusal of insulin. An interview was conducted with Licensed Nurse 2 (LN 2) on 6/11/25 at 1:05 P.M. LN 2 stated if blood sugar levels were outside the parameters set by the physician, then LNs were responsible for notifying the physician and documenting the physician's response, along with any new orders. LN 2 stated untreated high blood sugar levels could lead to diabetes ketoacidosis (DKA-a serious, life-threatening complication of diabetes), coma, and even death. An interview was conducted with LN 3 on 6/11/25 at 1:07 P.M. LN 3 stated the physician needed to be informed immediately if the blood sugar levels were outside the parameters set. LN 3 stated LNs were expected to document when the physician was and if additional insulin was ordered. LN 3 stated if there was no documentation of the physician being notified, then it was not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the Director of Nursing (DON), on 6/11/25 at 1:20 P.M. The DON reviewed Resident 1's physician's order to blood sugar parameters and then reviewed the MAR. The DON stated Resident 1's blood sugar level was 343 on the morning of 6/11/25, which was outside the parameter set for 250. The DON could not find any documented evidence from nursing staff that the physician was notified of the abnormal blood sugar level. The DON stated hyperglycemia could cause harm to the resident, and the physician should have been notified so an intervention could have been implemented. According to the facility's policy, titled Medication and Treatment Orders, dated July 2016, 'Orders for medications and treatment will be consistent with principals of safe and effective order writing . The facility was unable to provide a policy related to hyperglycemia.