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	04/01/2026

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 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 did not develop patient centered care plans for two of four residents reviewed for care plans (Resident 1 and Resident 3) when: 1. A care plan was not developed to address Resident 1's behavior at the facility's garden area, 2. A care plan was not developed to address Resident 1's discharge plan and intent to leave the facility against medical advice (AMA), 3. A care plan was not developed for Resident 3's placement preference. This failure had the potential for residents not to receive care based on their needs.FINDINGS: On 4/1/26 at 1:16 P.M., an unannounced onsite visit at the facility was conducted related to a reported resident elopement. 1.Resident 1 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (bone infection) of the left ankle and foot according to the facility's admission Record. During an interview on 4/1/26 at 1:18 P.M. with the Director of Nursing (DON), the DON stated on 3/27/26, she was notified that Resident 1 eloped from the facility. The DON stated Resident 1 was on intravenous (IV- into the vein) antibiotics and had a peripherally inserted central catheter (PICC-a thin, flexible tube inserted into a vein in the upper arm used for intravenous medications). The DON stated Resident 1's wife told her that Resident 1 had a history of illicit drug (any substance prohibited from manufacture, sale or possession due to its illegal status, dangerous in nature, or high potential for misuse) use. A review of progress notes (PN) in the electronic medical record (EMR) for Resident 1 was conducted. A PN dated 3/19/26 titled, Behavior Note indicated Resident 1 mentioned being in a drug rehab program for chronic marijuana (an illegal substance which affects the brain responsible for memory, learning, attention, decision making, coordination, emotions and reaction time) use. A review of Resident 1's hospital consultation dated 3/3/26 at 3:46 P.M. indicated, Substance Abuse Use: Marijuana. Frequency: Daily. A review of Resident 1's care plans indicated no care plan regarding Resident 1's history of illicit drug use. An interview on 4/1/26 at 4:18 P.M. with the DON was conducted. The DON stated there was no care plan regarding Resident 1's illicit drug use. The DON stated there should be a care plan to maintain resident's safety with interventions to prevent use, overdose and access to the drug or substance. 2. During a review of PN completed by the Assistant Director of Nursing (ADON) for Resident 1 dated 3/26/27 at 6:45 P.M., the PN indicated a meeting was held with Resident 1 to discuss Resident 1's gardening activities. The PN indicated, Resident was educated on facility guidelines and safety protocols related to gardening. Resident verbalized dissatisfaction with the guideline and stated he preferred to engage in gardening activities without limitation. Resident expressed intent to leave the facility AMA or transfer to another facility if guidelines were not modified. mentioned facility had until tomorrow, otherwise he would go AMA. An interview on 4/1/26 at 1:44 P.M. was conducted with Licensed Nurse (LN)1. LN 1 stated Resident 1's usual routine was to go out to the facility's garden because Resident 1 had told her that he used to garden. During an interview on 4/1/26 at 2:21 P.M with LN 2, LN2 stated Resident 1 was frequently at the facility's garden replanting plants on pots. An interview on 4/2/26 at 10:10 A.M. was conducted with ADON. The ADON stated a meeting was held with Resident 1 because the activity staff complained about the resident who pulled out live plants from the garden that residents or staff (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planted. The ADON stated she was unsure if Resident 1 pulled the plants from pots or from the ground. The ADON stated Resident 1 was offered an individualized planting session or designated spot in the garden but Resident 1 was not in agreement and instead requested to be transferred to another facility or Resident 1 would leave the facility AMA. The ADON stated she reviewed Resident 1's care plans in the EMR and there was no care plan regarding Resident 1's behavior in the garden, discharge planning and/or Resident 1's intent to leave AMA. The ADON stated care plans should have been completed to address Resident 1's behavior and to have interventions to prevent Resident 1 from leaving AMA and to provide a safe discharge. 3. Resident 3 was admitted to the facility on [DATE] with diagnoses Traumatic Brain Injury (a sudden and violent blow to the head causing damage to the brain) according to the facility's admission Record. An interview and joint record review on 4/1/26 at 1:55 P.M. was conducted with the front desk receptionist (REC). The REC stated she was familiar with residents who were at risk for elopement. The REC stated a Wanderguard List binder was kept at the front desk with a list of residents at risk for elopement. The REC showed Resident 3's photo on the binder. An interview and joint record review on 4/1/26 at 4:15 P.M. was conducted with the DON. The DON stated Resident 3 was a long-term care resident of the facility. The DON reviewed Resident 3's care plans and stated there was a care plan dated 8/29/24 which indicated Resident 3 was at risk for elopement. The DON stated there was no care plan regarding discharge or placement preference for Resident 3. The DON stated there should be a care plan even if a resident was for long term care. During a follow up interview on 4/1/26 at 4:18 P.M. with the DON, the DON stated residents should have discharge planning care plans to reflect proper placement per resident's preferences. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/22 was conducted. The P&P indicated, A comprehensive, person-centered care plan that includes, measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.