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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Escondido Post Acute	421 E Mission Ave Escondido, CA 92025

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on interview, record review, and facility policy review, the facility failed to assess a resident's ability to self-administer their medication for 1 (Resident #153) of 33 sampled residents. Findings included: A facility policy titled, Self-Administration of Medications, with a copyright date of 2001, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. An Admission Record revealed the facility admitted Resident #153 on 02/12/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of rhabdomyolysis (a breakdown of muscle tissue). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/19/2025, revealed Resident #153 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Resident #153's comprehensive Care Plan Report with an admitted [DATE], revealed no care plan to indicate the resident could self-administer their medications and/or keep medications at their bedside. Resident #153's Order Summary Report, with active orders as of 05/05/2025, did not include an order for Tums (an over-the-counter antacid medication). Resident #153's medical record revealed no evidence to indicate the resident could self-administer their medications and/or keep medications at their bedside. During a concurrent observation and interview on 05/05/2025 at 10:28 AM, the surveyor noted a bottle of Tums on Resident #153's bedside table. Resident #153 stated staff were aware the medication was in their room and added a family member brought the medication to them. During an observation on 05/06/2025 at 1:30 PM, Resident #153 was not in their room, but the surveyor noted a bottle of Tums on the resident's nightstand. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/07/2025 at 9:58 AM, Resident #153 was noted lying in bed with their eyes closed but answered when spoken to. There was a bottle of Tums noted on the resident's nightstand. Certified Nursing Assistant (CNA) #3 was interview on 05/07/2025 at 10:17 AM and stated if she saw medication at a resident's bedside she called the nurse because she was not allowed to remove medication by herself. CNA #3 stated she had not seen any medication by Resident #153's bedside. CNA #3 stated she had been assigned to care for Resident #153 on 05/05/2025 and 05/06/2025.CNA entered Resident #153's room, saw the medication on the nightstand, and stated she had not noticed the medication on 05/05/2025 or 05/06/2025. Resident #153 was interviewed on 05/07/2025 at 10:23 AM and stated they took Tums every night for their stomach. Resident #153 stated they wanted to be able to keep the medication at their bedside and take the medication as needed. Licensed Vocational Nurse (LVN) #4 was interviewed on 05/07/2025 at 10:23 AM and stated there were no residents on the unit that self-administered medications. LVN #4 stated if she saw medication at a resident's bedside she would remove the medication since residents were unable to self-administer medications without a physician's order and again stated no resident on her assignment had an order for self-administration. LVN #4 stated the hall had also been assigned to her on 05/05/2025. LVN #4 stated she was unaware Resident #153 had medication at their bedside. LVN #4 stated if Resident #153 wanted to self-administer medication, she was responsible for the self-administration assessment. LVN #4 went into Resident #153's room and removed the bottle of Tums. LVN #4 added she would call the resident's physician and request an order for Resident #153 to self-administer the medication. The Director of Nursing (DON) was interviewed on 05/07/2025 at 10:31 AM. The DON stated that prior to any resident self-administering medication the resident had to be assessed to see if it was safe for the resident to self-administer. The DON stated the physician would be made aware of the resident's desire to self-administer and an order would be obtained for self-administration and to keep the medication at the bedside. The DON stated the facility would plan for storage of the medication to keep the medication out of the reach of other residents. The DON stated she was unaware of any resident that had orders to self-administer medications, including any over-the-counter medications. The DON stated if medication was seen at a resident's bedside she expected staff to remove the medication. The Administrator was interviewed on 05/08/2025 at 10:06 AM. The Administrator stated he would not expect medication to be left at Resident #153's bedside. The Administrator stated he expected staff to be more observant and to remove medication from the resident's room.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37935 Based on interview, record review, and facility policy review, the facility failed to ensure beneficiary notifications were completed accurately for 2 (Resident #128 and Resident #143) of 3 sampled residents reviewed for beneficiary notices. Findings included: A facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised 09/2024, indicated, 4. Written notices are provided in person to the beneficiary when possible. A copy of the notice is provided to the beneficiary (or authorized representative) immediately after the notice is signed. 1. An Admission Record revealed the facility admitted Resident #128 on 12/03/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy. A skilled nursing facility (SNF) Part A Prospective Payment System (PPS) [NAME] Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2025, revealed Resident #128 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. An undated Advance Beneficiary Notice of Non-coverage (ABN) for Resident #128 revealed the section titled E. Reason Medicare May Not Pay was left blank. The notice revealed the options listed in the section titled G. Options: Check only one box. We cannot choose a box for you was blank. Further review revealed the notice was not signed or dated. During an interview on 05/08/2025 at 9:20 AM, Business Office Manager (BOM) #1 stated he had missed it. BOM #1 stated the ABN for Resident #128 was not signed or dated. He stated the ABN for Resident #128 was not filled out completely due to no options being selected in Section G. He stated Section E should not have been left blank. He stated the ABN should have been filled out completely and signed and dated. He stated he should have reached out to Resident #128's representative to have them sign the ABN and should have issued a Notice of Medicare Non-coverage (NOMNC). BOM #1 stated he did not issue a NOMNC to Resident #128. During an interview on 05/08/2025 at 9:38 AM, the Director of Nursing (DON) stated she was not involved in the beneficiary notification process. The DON stated she expected notifications to be filled out completely and correctly. She stated she also expected them to be issued within 48 hours of the effective date. During an interview on 05/08/2025 at 9:46 AM, the Administrator stated he was not involved in the beneficiary notification process. The Administrator stated he expected notifications to be filled out accurately and completely. The Administrator stated he expected NOMNCs to be issued in the time allowed. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An Admission Record revealed the facility admitted Resident #143 on 11/07/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of an unspecified fracture of the left tibia shaft. A skilled nursing facility (SNF) Part A Prospective Payment System (PPS) [NAME] Data Set (MDS), with an Assessment Reference Date (ARD) of 02/14/2025, that revealed Resident #143 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #143's Advance Beneficiary Notice of Non-coverage (ABN), dated 02/11/2025, revealed the section titled E. Reason Medicare May Not Pay was left blank. The notice revealed the options listed in the section titled G. Options: Check only one box. We cannot choose a box for you was blank. During an interview on 05/08/2025 at 9:20 AM, Business Office Manager (BOM) #1 stated the ABN for Resident #143 did not have an option selected under Section G. The BOM stated an option should have been chosen and since there was not an option chosen then the form was not filled out correctly. The BOM stated Section E should not have been left blank. He stated he did not issue Resident #143 a Notice of Medicare Non-coverage (NOMNC) due to a lack of communication and dropped the ball on issuing it. He stated the ABN should have been filled out completely and signed and dated. During an interview on 05/08/2025 at 9:38 AM, the Director of Nursing (DON) stated she was not involved in the beneficiary notification process. The DON stated she expected notifications to be filled out completely and correctly. The DON stated she also expected them to be issued within 48 hours of the effective date. During an interview on 05/08/2025 at 9:46 AM, the Administrator stated he was not involved in the beneficiary notification process. The Administrator stated he expected notifications to be filled out accurately and completely. The Administrator stated he expected NOMNCs to be issued in the time allowed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 52520 Based on interview, record review, and facility policy review, the facility failed to report timely, an allegation of verbal abuse to the state survey agency for 1 (Resident #23) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a copyright date of 2001, indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy specified, 9. Investigate and report any allegations within timeframes required by federal requirements. An Admission Record specified the facility admitted Resident #23 on 06/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of muscle weakness, need for assistance with personal care, and hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/2025, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During an interview on 05/05/2025 at 2:28 PM, Resident #23 stated their former roommate, Resident #371, had threatened and was very mean to them. Per Resident #23, they woke up one day and found Resident #371 going through their dresser and pulling out their things. Resident #23 stated they told Resident #371 to stop and that was when Resident #371 cursed, yelled and accused them of stealing their things. Resident #23 stated Resident #371 did not physically touch them but yelled all the time at them. According to Resident #23, Resident #371 was moved to another room on another unit. Resident 23 stated they were told that Resident #371 would be kept on another unit in the facility. Resident #23 acknowledged they were scared of Resident #371. During an interview on 05/05/2025 at 4:15 PM, the Administrator was made aware of the allegations of abuse reported by Resident #23. The Administrator stated he was not aware, would initiate an investigation, and report any findings to the surveyor on 05/06/2025. During an interview on 05/06/2025 at 8:52 AM, the Administrator stated he attempted to speak with Resident #23 on 05/05/2025, but the resident reported they were tired and did not want to talk. According to the Administrator, an investigation was being conducted and he would decide if the resident's allegation needed to be reported to the state survey agency. During an interview on 05/06/2025 at 10:06 AM, the Director of Nursing (DON) and Administrator acknowledged the allegation of abuse reported by Resident #23 was reported to the state survey agency on 05/06/2025 at 9:30 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/2025 at 2:53 PM, the DON stated she was informed by the Administrator on 05/05/2025 at 4:45 PM, that Resident #23 alleged their former roommate was verbally abusive to them. During an interview on 05/07/2025 at 3:45 PM, the Administrator stated he was made aware by the surveyor of Resident #23's allegation of abuse on 05/05/2025 at 4:15 PM. Per the Administrator, Resident #23 reported their former roommate was verbally abusive to them. The Administrator confirmed the allegation of verbal abuse was reported to the state survey agency on 05/06/2025 at 9:30 AM. According to the Administrator, allegations of abuse should be reported within two hours and it was his fault that Resident #23's allegation of verbal abuse was not timely reported. The Administrator stated that allegations of abuse should be timely reported.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 22445 Based on interview, record review, and facility policy review, the facility failed to ensure staff submitted a new Preadmission Screening and Resident Review (PASRR) to the state agency for review after a significant change in status occurred for 1 (Resident # 53) of 5 residents reviewed for PASRR. Findings included: A facility policy titled, PASRR (Pre-Admission Screening & [and] Resident Review), dated 06/2018, indicated, 3. A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. An Admission Record revealed the facility admitted Resident #53 on 04/03/2016. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified cerebral infarction (stroke), unspecified schizophrenia (with an onset date of 05/08/2018), and other specified depressive episodes (with an onset date of 05/08/2018). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2025, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #53 had no hallucinations, delusions, or behaviors. The MDS indicated Resident #53 had active diagnoses that included depression and schizophrenia. Resident #53's Care Plan Report, included a focus area initiated 07/15/2024, that indicated the resident used antidepressants for major depressive disorders and insomnia. Interventions directed staff to administer the antidepressant medication as ordered by the physician, observe the resident's mood and response to the medication, consider non-pharmacological approaches, and consult psychology as needed. The Care Plan Report indicated a focus area initiated 02/17/2023, that indicated the resident had a diagnosis of schizophrenia. Interventions directed staff to assist the resident, family, and caregivers to identify strengths and positive coping skills; behavioral health consults as needed; and monitor, document, and report any risks for harm. A State of California-Health and Human Services Agency Preadmission Screening and Resident Review (PASRR) Level I Screening Document, dated 04/03/2016, indicated Resident #53 had a negative Level I PASRR due to having no mental illness such as schizophrenia or depression. Resident #53's Diagnosis Report revealed unspecified schizophrenia and other specified depressive episodes were added as active diagnoses for Resident #53 on 05/08/2018. The report revealed the section titled Comments indicated that a PASRR Level II was not required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53's Order Summary Report, with orders active as of 05/05/2025, included an order dated 02/23/2024, for Paxil (an antidepressant) 30 milligrams (mg), with instructions to give 0.5 tablet by mouth one time a day for depression as evidenced by expressions of sadness. The Order Summary Report included an order dated 01/20/2025, for trazadone (an antidepressant that is also used for insomnia) 50 mg, with instructions to give one tablet by mouth at bedtime for depression as evidence by inability to sleep. On 05/06/2025 at 2:19 PM, the Administrator stated he was unsure who was responsible for submitting a new PASRR to the state agency when a resident had a change in condition. During a follow-up interview on 05/06/2025 at 2:59 PM, the Administrator stated the PASRR process was multifaceted and multileveled. The Administrator stated the Admissions Director was the first line of defense when she looked at PASRRs for admission to the facility. He stated that after admission, the MDS department was the follow-up for any process questions related to a resident's PASRR. The Administrator stated the Director of Nursing (DON) would then follow up and review the PASRR for completion and accuracy. The Admissions Director was interviewed on 05/07/2025 at 8:48 AM. The Admissions Director stated the PASRR was sent to the facility from the hospital on an electronic file exchange and she had no access to the file exchange. She stated the nurses had access to the electronic file exchange portal, but she was unsure who was responsible for sending information to the state agency when a change in a resident's condition occurred or the resident received a new psychiatric diagnosis. The Director of Social Services (DSS) was interviewed on 05/07/2025 at 9:02 AM. The DSS stated she had no responsibility for reviewing a resident's PASRR or making sure the PASRR was accurate. The DSS stated the MDS Coordinator #17 was responsible for submitting a new PASRR for review to the state agency when a psychiatric diagnosis was added for a resident. MDS Coordinator #17 was interviewed on 05/07/2025 at 9:12 AM. MDS Coordinator #17 stated the previous admission nurse had been responsible for reviewing residents' PASRRs on admission for accuracy. MDS Coordinator #17 stated she was unaware of any current residents who had a new psychiatric diagnosis added, but if there had been a resident with a new psychiatric diagnosis added it was the responsibility of the MDS department to submit the information to the state agency for review. MDS Coordinator #17 stated she had worked in the facility for three years, and prior to her arrival submitting new information to the state agency for review was the responsibility of the MDS department and the DON. MDS Coordinator #17 reviewed the diagnoses list for Resident #53 and confirmed that depression and schizophrenia had been added in 2018. She stated this information should have been sent to the state agency for review, since the addition of new diagnoses indicated a significant change in status for Resident #53. MDS Coordinator #17 stated the facility had not designated anyone to review PASRRs for accuracy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 05/07/2025 at 10:41 AM. The DON stated if psychiatric diagnoses were added to a resident's profile after admission the MDS department was notified and a new Level I PASRR was submitted to the state agency due to the resident's significant change in condition. The DON stated that during the quarterly reviews, the PASRRs were reviewed along with any new diagnoses. The DON stated the MDS nurses or the nurses on the floor should have caught the addition of Resident #53's new diagnoses and stated the PASRR was not accurate. The DON stated that although the diagnoses were added in 2018, the expectation was for residents' PASRRs and their diagnoses to be reviewed quarterly. The DON stated the 2016 PASRR was the only one on file in the facility for Resident #53. The Administrator was interviewed on 05/08/2025 at 10:03 AM. The Administrator stated he expected someone to catch the error on the resident's PASRR, the new diagnoses, and to submit a new PASRR to the state agency.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 28193 Based on observation, interview, facility document review, and facility policy review, the facility failed to provide necessary treatments and services consistent with professional standards of practice during wound care for 1 (Resident #150) of 2 residents reviewed for pressure ulcers. Findings included: A facility policy titled, Wound Care, revised 10/2010, revealed, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The policy revealed the section titled, Preparation, included, 1. Verify that there is a physician's order for this procedure and 3. Assemble the equipment and supplies as needed. A facility policy titled, Physician Orders, revised 06/2013, revealed, Physician orders must be given, managed and carried out in accordance with applicable laws and regulations. Resident #150's Admission Record indicated the facility admitted the resident on 01/17/2025. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, cellulitis of the right lower limb, fracture of the right great toe, pressure induced deep tissue damage of the left heel, and pressure induced deep tissue damage of the right heel. A Medicare 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2025, revealed Resident #150 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive to total assistance for all activities of daily living (ADLs). Resident #150's Care Plan Report, included a focus area initiated 02/11/2024 and revised 04/24/2025, that indicated the resident had a left deep tissue injury (DTI) and was at risk for further breakdown and/or slow, delayed healing related to cardiovascular disease, incontinence of bladder, and incontinence of bowel. The focus area also indicated Resident #150 had a right heel DTI that had resolved. Interventions (initiated 2/11/2025) directed staff that the resident had a pressure-reduction cushion for their chair, a turning and repositioning wedge, and used lift pads to minimize friction and shear. Interventions directed staff to provide vitamins and nutritional supplements as ordered (initiated 2/11/2025). Resident #150's Physician Orders Details dated 05/06/2025, from the wound care provider, revealed Resident #150 had received treatment orders for Wound #1 Left Heel, Wound #2 Right Heel, Wound #3 Right, Medial Second Toe, and Wound #4 Right Third Toe Tip. Resident #150's Order Recap [Recapitulation] Report, for the timeframe from 01/01/2024 through 05/31/2025, revealed the following treatment orders: - An order dated 05/06/2025, for TX [treatment] orders for abrasion @ [at] R [right] 3rd toe. Apply topical Lidocaine 2% [percent] to wound bed. Cleanse with NS [normal saline], pat dry. Notify MD [medical doctor] if changes occur. Reassess in 14 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 05/06/2025, for TX orders for abrasion @ R medial 2nd toe. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply skin prep to surrounding skin, insert HFB [Hydrofera Blue] and cover with foam dressing. Notify MD if changes occur. Reassess in 14 days. - An order dated 05/06/2025, for TX orders for s/p [status post] DTI @ L [left] heel. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply skin prep to periwound, let dry, apply foam dressing. Notify MD if changes occur. Reassess in 14 days. Every day shift every Wed [Wednesday], Sat [Saturday] for L heel. - An order dated 05/06/2025, for TX orders for s/p DTI @ R heel. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply Skin Prep to periwound, let dry, apply foam dressing. Notify MD if changes occur. Reassess in 14 days. every day shift every Wed, Sat for R heel. During an observation of wound care on 05/07/2025 at 10:04 AM, Licensed Vocational Nurse (LVN) #2 gathered wound care supplies from the treatment cart, knocked on Resident #150's room door, and entered the resident's room. LVN #2 removed the blankets from the resident's lower legs and feet, placed a barrier pad underneath the resident's feet, and removed Resident #150's socks. LVN #2 removed a dressing from the resident's left heel. There was no dressing present on the resident's right heel to remove. LVN #2 then peeled back the soiled dressing from Resident #150's right second toe and using a syringe, put Lidocaine on the wound bed and laid the soiled dressing back over the wound; per LVN #2, she did it to let it soak a little. LVN #2 then cleaned the right heel wound and left heel wound with normal saline and gauze and applied skin prep around the wound bed of both heels. LVN #2 then took a pair of bandage scissors from her pocket and cut two dressings to fit over both heel wounds and placed the bandages on both heels. LVN #2 then removed the dressing from Resident #150's right second toe wound and cleaned the wound with normal saline and gauze. LVN #2 then cut a small piece of Hydrofera Blue foam and placed it over the wound bed of the right second toe. Once the Hydrofera Blue foam was in place, LVN #2 took a 5-inch by 5-inch adhesive bordered foam dressing and placed it over the end of Resident #150's right foot, enclosing all their toes on the right foot in the dressing. LVN #2 did not address the wound on Resident #150's right third toe during the wound treatment. She then placed the resident's socks back on both feet and pulled the blankets back from their lower legs. LVN #2 threw away the soiled supplies and placed the Lidocaine syringe into the sharps container on the treatment cart and documented the treatments as completed. During an interview on 05/07/2025 at 12:19 PM, LVN #2 stated she had worked at the facility for two years and had been doing Resident #150's wound treatments since February 2025. LVN #2 stated the resident's wound treatments had been changed by the wound clinic the day prior. LVN #2 stated that the Lidocaine was for the second toe mainly, because it was painful to the resident during the dressing change, the other wounds on both heels quit hurting the resident about two weeks ago when the wounds started to close up, so she did not put it on any other wound but the second toe. LVN #2 stated there was no dressing change order for the wound on the residents right third toe. LVN #2 stated she put a dressing over the entire end of the resident's foot to help protect all the toes and did not think about the possibility that the resident's toes would be pressed together and could create more pressure between the toes. LVN #2 stated she had not followed the physician's orders for wound treatments. (continued on next page)

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	056040	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Escondido Post Acute	421 E Mission Ave Escondido, CA 92025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2025 at 10:58 AM, the Director of Nursing (DON) stated that not following the physician's orders to use Lidocaine on all of Resident #150's wounds and not dressing their third toe at all, were all issues. The DON stated her expectation was for the nurse to verify the physician's order for the resident prior to gathering their supplies, and they must follow the physician's order and prepare the supplies according to the order. During an interview on 05/08/2025 at 11:19 AM, the Administrator stated his expectation was that the nurses follow the physician's orders exactly as written.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 52219 Based on observation, interview, and facility policy review, the facility failed to post nurse staffing information at the beginning of each shift during three of four days of the survey. This deficient practice had the potential to affect all residents who currently resided in the facility. Findings included: A facility policy titled, Posting Direct Care Daily Staffing Numbers, with a copyright date of 2001, revealed, Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The policy specified, 1. Within two (2) hours of the beginning of each shift, the number of licensed nurse (RNs [registered nurses], LPNs [licensed practical nurses], and LVNs [licensed vocational nurses]) and the number of unlicensed nursing personnel (CNAs and NAs) [certified nursing assistants and nurse aides] directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. During an observation on 05/05/2025 at 9:41 AM, the posted nurse staffing information was located at the receptionist desk in the lobby and was dated 05/02/2025. During an observation 05/06/2025 at 8:39 AM, the posted nurse staffing information was located at the receptionist desk in the lobby and was dated 05/05/2025. During a concurrent observation and interview on 05/07/2025 at 7:55 AM, the posted nurse staffing information was dated 05/06/2025. The Admissions Assistant stated she posted the staffing data every day in the morning and not prior to each shift. During an observation on 05/07/2025 at 4:55 PM, the posted nurse staffing information was located at the receptionist desk, was dated 05/07/2025, and the staffing was listed for all three shifts. During an interview on 05/07/2025 at 1:08 PM, Certified Nursing Assistant (CNA) #16 stated the nurses worked either the 7:00 AM - 3:30 PM shift, 3:00 PM - 11:30 PM shift or the 11:00 PM - 7:30 AM shift and the CNAs worked either the 6:00 AM - 2:30 PM shift, 2:30 PM - 10:30 PM shift, or the 10:30 PM - 6:30 AM shift. During a follow-up interview on 05/07/2025 at 1:29 PM, CNA#16 stated she posted the staffing data when she arrived to work at 8:00 AM for the entire day. CNA #16 confirmed she did not post the nurse staffing data at the beginning of each shift. During an interview on 05/07/2025 at 1:29 PM, the Director of Staff Development (DSD) stated the staff posting was preprogrammed in the software and was posted for twenty-four hours. The DSD stated she did not know nurse staffing data should be posted prior to the beginning of each shift. During an interview on 05/08/2025 at 10:25 AM, the Director of Nursing (DON) stated her expectation was the staff posting should be identifiable, clear, and in a separate location. The DON stated the nurse staffing posting should be changed prior to each shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 05/08/2025 at 12:13 PM, the Administrator stated the nurse staffing data should be posted two hours before each shift.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on observation, interview, record review, and facility policy review, the facility failed to implement infection control practices during wound care for 1 (Resident #150) of 2 residents reviewed for pressure ulcers, and failed to ensure proper storage of oxygen and nebulizer equipment, when not in use, to prevent the spread of infection for 1 (Resident #278) of 1 resident reviewed for respiratory care. Findings included: 1. A facility policy titled, Wound Care, revised 10/2010, revealed, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The policy revealed the section titled, Steps in the Procedure, included, 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. Further review revealed, 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. The policy revealed, 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. The policy revealed, 12. Remove dry gauze. Apply treatments as indicated. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply to dressing. 14. Be certain all clean items are on the clean field. The policy revealed, 19. Use clean field saturated with alcohol to wipe overbed table. Per the policy, 23. Wash and dry your hands thoroughly. A facility policy titled, Enhanced Barrier Precautions, dated 12/2024, revealed, Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The policy revealed, 2. Enhanced barrier precautions apply when: b. A resident is NOT known to be infected or colonized with an MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained. The policy revealed, 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). The policy revealed, 8. Examples of high-contact care activities requiring the use of gown and gloves for EBPs include: j. wound care (any skin opening requiring a dressing.) The policy revealed, 11. Outside the resident's room, EBPs are indicated when anticipating close physical contact, including performing transfers or assisting during bathing and a shared/common shower room and when working with the residents in the therapy gym. 12. Enhanced barrier precautions are in place for the duration of the residents' stay of until resolution of the wound or discontinuation of the indwelling medical device that place that at higher risk. The policy revealed, 17. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE [personal protective equipment] required. 18. personal protective equipment and alcohol-based hand rub are readily accessible to staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Handwashing/Hand Hygiene, revised 10/2023, revealed, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The policy revealed, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The policy revealed the section titled, Indications for Hand Hygiene, included, 1. Hand hygiene is indicated: a. immediately before touching a resident; c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching a resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. 2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. Resident #150's Admission Record indicated the facility admitted the resident on 01/17/2025. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, cellulitis of the right lower limb, fracture of the right great toe, pressure induced deep tissue damage of the left heel, and pressure induced deep tissue damage of the right heel. A Medicare 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2025, revealed Resident #150 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive to total assistance for all activities of daily living (ADLs). Resident #150's Care Plan Report, included a focus area initiated 02/11/2024 and revised 04/24/2025, that indicated the resident had a left deep tissue injury (DTI) and was at risk for further breakdown and/or slow, delayed healing related to cardiovascular disease, incontinence of bladder, and incontinence of bowel. The focus area also indicated Resident #150 had a right heel DTI that had resolved. Interventions (initiated 2/11/2025) directed staff that the resident had a pressure-reduction cushion for their chair, a turning and repositioning wedge, and used lift pads to minimize friction and shear. Interventions directed staff to provide vitamins and nutritional supplements as ordered (initiated 2/11/2025). Resident #150's Order Recap [Recapitulation] Report, for the timeframe from 01/01/2024 through 05/31/2025, revealed the following treatment orders: - An order dated 05/06/2025, for TX [treatment] orders for abrasion @ [at] R [right] 3rd toe. Apply topical Lidocaine 2% [percent] to wound bed. Cleanse with NS [normal saline], pat dry. Notify MD [medical doctor] if changes occur. Reassess in 14 days. - An order dated 05/06/2025, for TX orders for abrasion @ R medial 2nd toe. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply skin prep to surrounding skin, insert HFB [Hydrofera Blue] and cover with foam dressing. Notify MD if changes occur. Reassess in 14 days. - An order dated 05/06/2025, for TX orders for s/p [status post] DTI @ L [left] heel. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply skin prep to periwound, let dry, apply foam dressing. Notify MD if changes occur. Reassess in 14 days. Every day shift every Wed [Wednesday], Sat [Saturday] for L heel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 05/06/2025, for TX orders for s/p DTI @ R heel. Apply topical Lidocaine 2% to wound bed. Cleanse with NS, pat dry, apply Skin Prep to periwound, let dry, apply foam dressing. Notify MD if changes occur. Reassess in 14 days. every day shift every Wed, Sat for R heel. On 05/07/2025 at 10:04 AM, during a wound care observation for Resident #150, it was noted that no EBP supplies were available outside the resident's room, nor were any EBP signs hung on or near the door. Licensed Vocational Nurse (LVN) #2 stated the resident had changed rooms the evening prior. LVN #2 donned gloves and gathered supplies for Resident #150's four wounds, laying them on top of the treatment cart without a barrier underneath. No gown for EBP was donned by LVN #2 prior to entering the resident's room. LVN #2 grabbed the wound care supplies, knocked on the door, entered the room, and placed the dressings, skin prep pads, multiple pairs of gloves, six gauze pads, three large foam pads, three cups of saline, a syringe of lidocaine, and a folded absorbent underpad on Resident #150's bedside table without a barrier under them, with the same gloves on that she used to gather the supplies from the treatment cart, LVN #2 removed the blanket from the resident's lower legs, grabbed the absorbent underpad, and placed it underneath the resident's bilateral feet. With the same gloves, the nurse removed the resident's socks from both feet. Without changing gloves, LVN #2 removed the soiled dressing from Resident #150's left heel. No dressing was present on the resident's right heel. Without changing gloves, the nurse peeled back the soiled dressing on the resident's right second toe and grabbed the syringe of lidocaine, placing some on the wound bed of the second toe, and then pushed the soiled dressing back down over the wound; per LVN #2 she did it to let it soak a little. Without changing gloves, LVN #2 grabbed a cup of normal saline and gauze and cleansed the resident's right heel wound. Without changing gloves, she grabbed a second cup of normal saline and gauze and cleansed the resident's left heel wound. Without changing gloves, LVN #2 grabbed a skin prep pad and wiped the skin around the right heel wound, and without changing gloves, grabbed another skin prep pad and wiped the skin around the resident's left heel wound. Without changing gloves, the nurse grabbed a pair of bandage scissors from her pocket, did not clean them, used the scissors to cut the foam dressing for Resident #150's right heel wound, placed the scissors back into her pocket, and then placed the dressing on the resident's foot. Without changing gloves, LVN #2 removed the scissors from her pocket again, and without cleaning them, cut the dressing for Resident #150's left heel, placed the scissors back into her pocket, and placed the dressing on the resident's left heel. Without changing gloves, LVN #2 removed the soiled dressing that had been replaced over the lidocaine gel on the resident's right second toe. Without changing gloves, she grabbed the last cup of normal saline and gauze and cleansed the wound bed. LVN #2 then removed her gloves for the first time during the wound treatment observation and walked out to the treatment cart to retrieve an additional dressing. LVN #2 put on gloves and grabbed a Hydrofera Blue dressing from the cart and brought it back into Resident #150's room. Without changing gloves, the nurse pulled the bandage scissors from her pocket, did not clean them, and cut a small piece of the dressing to cover the wound on the resident's second toe. Without changing gloves, she took a 5-inch by 5-inch adhesive bordered dressing and placed it over all of the resident's toe, encapsulating the entire end of the resident's foot. Without changing gloves, she placed the resident's socks back on and rolled up the dirty supplies into the absorbent underpad and [NAME] it in the trash. She placed the lidocaine syringe into the sharps container on the treatment cart and removed her gloves and sanitized her hands; this was the first time LVN #2 sanitized her hands in between glove changes during the wound care observation. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/2025 at 12:19 PM, LVN #2 stated she had worked at the facility for two years and had been doing Resident #150's wound treatments since February 2025. LVN #2 stated the resident's treatments had been changed the day prior while they were at the wound clinic. LVN #2 stated that for the scissors in her pocket, she had three pairs of scissors on the treatment cart, and she would switch them out between patients, but she did not clean them in between dressing changes and should not have put them back in her pocket. LVN #2 stated she needed to remember to think about cross contamination when she moved from clean to dirty tasks with wounds. She stated she wore PPE required for EBP for some residents with wounds that she treated but only for the residents with wounds that were draining or had an MDRO in the wound bed. She stated she did not wear the PPE required for EBP for all the wound treatments that she completed. LVN #2 further stated Resident #150 did not have an EBP bin on their door because they had just been moved the evening prior to a new room, and it must not have been brought over with the resident. During an interview on 05/05/2025 at 10:58 AM, the Director of Nursing (DON) stated not placing a barrier under the wound supplies, not changing gloves between clean and dirty portions of the wound care, not sanitizing hands between glove changes, not cleaning the scissors the nurse kept putting in her pocket, and not wearing a gown for EBP were all issues and breaches of infection control. The DON stated her expectation was for the nurses to follow infection control practices from start to finish including wearing the PPE required for EBP, placing barriers under the wound supplies, not cross contaminating between wounds by completing wound care for one wound at a time, and changing gloves between clean and dirty tasks with hand sanitization or washing hands in between glove changes. During an interview on 05/08/2025 at 11:19 AM, the Administrator stated his expectation was for infection control policies to be adhered to, including EBP, during wound care to prevent infections. 2. A facility policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, revealed the section titled, Infection Control Considerations Related to Oxygen Administration, included, 3. Keep the oxygen cannula and tubing used PRN [pro re nata; as needed] in a plastic bag when not in use. The policy revealed the section titled, Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol, included, 7. Store the circuit in plastic bad, marked with date and resident's name, between uses. Resident #278's Admission Record indicated the facility admitted the resident on 04/24/2025. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and acute respiratory distress syndrome. Resident #278's Care Plan Report, included a focus area initiated 04/25/2025, that indicated the resident was at risk for complications with the respiratory system due to COPD. Interventions (initiated 04/25/2025) directed staff to administer medications as ordered and monitor for side effects/adverse reactions and effectiveness, administer nebulizer treatments as ordered, and for oxygen therapy as ordered. Resident #278's Order Summary Report, with active orders as of 05/07/2025, revealed an order dated 04/28/2025, for supplemental oxygen via nasal cannula 2 to 3 liters per minute (lpm) as needed to maintain oxygen saturation greater than 92%. The Order Summary Report included an order dated 04/25/2025, for ipratropium-albuterol solution 0.5-2.5 milligrams (mg) per milliliter (ml), with instructions to inhale orally via a nebulizer every four hours as needed for shortness of breath or wheezing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/05/2025 at 9:48 AM, Resident #278's oxygen nasal cannula was wrapped around the bed rail uncovered and Resident #278's nebulizer mask and medication reservoir were uncovered on the bedside dresser. During an observation on 05/05/2025 at 1:13 PM, Resident #278's oxygen nasal cannula remained wrapped around the bed rail uncovered, and the nebulizer mask and medication reservoir were on the bedside dresser uncovered. During an observation on 05/06/2025 at 10:16 AM, Resident #278's oxygen nasal cannula remained wrapped around the bed rail uncovered, and the nebulizer mask and medication reservoir were noted on the bedside dresser uncovered. During an observation on 05/06/2035 at 2:49 PM, Resident #278's oxygen tubing was not present in the room; however, the nebulizer mask and medication reservoir remained on the bedside dresser uncovered. Resident #278 was noted in the hallway with the nasal cannula and tubing attached to a portable tank on the back of the wheelchair. During a concurrent interview Resident #278 stated that a covering for their oxygen tubing had not been supplied and that they wrapped the tubing around their bedrail when they left their room to keep it off the floor. During an interview on 05/08/2025 at 11:05 AM, the Director of Nursing (DON) stated oxygen supplies and nebulizer equipment were supposed to be bagged and not touching the floor at any time when not in use. During a concurrent observation of Resident #278's room, the DON verified that the resident's oxygen nasal cannula and tubing were stuffed into the handle of the oxygen concentrator and were not bagged or covered. The DON verified the nebulizer mask and medication reservoir were sitting on top of the resident's two-drawer dresser and was uncovered. During an interview on 05/08/2025 at 11:28 AM, the Administrator stated he expected the nurses and nursing staff to follow the infection control practices for the storage of oxygen supplies and nebulizers.