

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a restraint was re-evaluated for one of one sampled resident (Resident 5) reviewed for physical restraint. This failure had the potential for Resident 5 to be restrained unnecessarily. Cross Reference F 636. Findings: Resident 5 was admitted to the facility on [DATE] with diagnoses which included dementia (impaired memory and thinking skills) with mood disturbance and a urinary catheter (a device that drains urine from the urinary bladder into a collection bag), per the facility's admission Record. On 8/11/25, a record review of Resident 5's minimum data set (MDS - a federally mandated resident assessment tool) dated, 7/10/25 was conducted. Per the MDS, Resident 5 had limb restraints. On 8/11/25, a record review of Resident 5's care plan initiated on 7/18/25 indicated, hand mittens were present upon admission. On 8/11/25, a record review of Resident 5's physician order was conducted. The physician's order dated 7/7/25 indicated, Pt. (Patient) to wear bilateral mittens at all times except on hygiene to protect self from scratching and unaware wounding of his face every shift. On 8/11/25, a record review of Resident 5's Treatment Administration Record (TAR) for July 2025 was conducted. The TAR indicated, the Licensed Nurses (LNs) signed off the mittens order for Resident 5 as implemented from 7/7/25 to 7/25/25. On 8/11/25 at 9:51 A.M., an observation of Resident 5 was conducted in his room. Resident 5 laid in bed with his eyes closed, with blanket to his torso and did not respond to his name. A urinary catheter was noted attached to the bed rails. On 8/12/25 at 2:13 P.M., a follow-up observation of Resident 5 was conducted in his room. Resident 5 laid in bed with his eyes closed, his upper extremities were exposed and no hand mittens noted. On 8/12/25 at 2:23 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 5 was confused. CNA 1 stated when Resident 5 was admitted, he had the hand mittens because he kept grabbing his urinary catheter while in the hospital. CNA 1 stated Resident 5 did not exhibit the behavior of pulling his urinary catheter during his stay at the facility. On 8/12/25 at 3:15 P.M., a concurrent review of Resident 5's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 reviewed Resident 5's document, titled TAR, dated July 2025. LN 1 stated the LNs signed off Resident 5's TAR indicating he had hand mittens on every shift. LN 1 stated Resident 5 was completely confused. LN 1 stated Resident 5 came to the facility with hand mittens on per Resident 5's family member's (FM) request. LN 1 stated Resident 5's FM informed the facility that Resident 5 needed the hand mittens to prevent him from pulling his urinary catheter. On 8/12/25 at 4:21 P.M., a concurrent review of Resident 5's clinical record and an interview was conducted with MDS Nurse (MDSN). The MDSN stated Resident 5 came with hand mittens and MDSN coded Resident 5 with limb restraint in the MDS tool. The MDSN stated Resident 5 had a history of scratching his face in the hospital. The MDSN reviewed Resident 5's TAR and stated the LNs signed off the hand mittens were in place and presented as used from 7/7/25 to 7/25/25. The MDSN stated, There was only a statement in the admission notes, and no assessment was done for Resident 5's hand mittens. The MDSN also stated there were no progress notes related to Resident 5's hand mittens in the LNs weekly notes. The MDSN stated there was no evaluation on the use of the hand mittens if Resident 5 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555146	Facility ID: 555146 If continuation sheet Page 1 of 9

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still needed them or not because it was a physical restraint. The MDSN stated anything that physically inhibited the resident's movement was considered restraint. On 8/14/25 at 1:07 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 5's hand mittens should have been reevaluated, and education should have been provided to Resident 5's FM to prevent unnecessary use of restraint. Per the facility's policy, titled Use of Restraint, revised 4/17, .Restraints shall only be used for the safety and well-being of the residents and after other alternatives have been tried unsuccessfully. When the use of restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written bed hold notice to the resident and or resident's Responsible Party (RP - an individual authorized by the resident to act as an official representative) upon transfer to the hospital for one of two residents (Resident 4) reviewed for hospitalization. This failure had the potential for Resident 4 and his RP being unaware of the bed hold duration and his right to return to the facility after hospitalization. Findings: A review of resident 4's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (can cause confusion, memory loss and loss of consciousness). The admission Record listed Resident 4's wife as the RP. Resident 4 was transferred to the hospital on 8/4/25 per Resident 4's wife due to difficulty breathing. On 8/12/25, a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) was conducted. The MDS dated [DATE] indicated, Resident 4 was sent to an acute hospital and was anticipated to return to the facility. On 8/12/25 at 3:23 P.M., an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 4 was sent out to the acute hospital due to the wife's request and Resident 4 was expected to return to the facility. LN 2 stated bed hold was not discussed to the resident and to the RP. LN 2 also stated a written bed hold notice was not given to Resident 4 and his RP. LN 2 stated there should have been a bed hold notice for Resident 4 to inform him and his RP that there was an available bed for him when the resident returned from the acute hospital. On 8/13/25 at 1:28 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated there was no bed hold provided to Resident 4 and his RP. The DSD stated the LNs should have provided bed hold to Resident 4 as part of the state process and as resident's rights to return to the facility. On 8/14/25 at 1:07 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated there was no bed hold offered to Resident 4. The DON stated the expectation of the facility was for bed hold to be offered to the residents and or their RPs when they were sent out to the acute hospital to assure the residents had options to return to the facility. A review of the facility's policy titled Bed-Holds and Returns, revised 10/22, indicated .Residents and/or representatives are informed (in writing) of the facility and state.bed hold policies.1. All residents/ representatives are provided written information regarding the facility and state bed hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and document the use of hand mittens for one of one sampled resident (Resident 5) reviewed for physical restraint. This failure had the potential for Resident 5 to be restrained unnecessarily. Cross Reference F 604. Findings: Resident 5 was admitted to the facility on [DATE] with diagnoses which included dementia with mood disturbance (impaired memory and thinking skills) and a urinary catheter (a device that drains urine from the urinary bladder into a collection bag), per the facility's Face Sheet. On 8/11/25, a record review of Resident 5's minimum data set (MDS - a federally mandated resident assessment tool) was conducted. Per the MDS dated [DATE], Resident 5's had limb restraint. On 8/11/25, a record review of Resident 5's care plan, initiated on 7/18/25 indicated, hand mittens were present upon admission. On 8/11/25, a record review of Resident 5's physician order. The physician's order dated 7/7/25 indicated, Pt. (Patient) to wear bilateral mittens at all times except on hygiene to protect self from scratching and unaware wounding of his face every shift. On 8/11/25, a record review of Resident 5's Treatment Administration Record (TAR) for July 2025 was conducted. The TAR indicated the Licensed Nurses (LNs) signed off the mittens order for Resident 5 as implemented from 7/7/25 to 7/25/25. On 8/11/25 at 9:51 A.M., an observation was conducted of Resident 5 in his room. Resident 5 laid in bed with his eyes closed, with blanket to his torso and did not respond to his name. A urinary catheter was noted attached to the bed rails. On 8/12/25 at 2:13 P.M., a follow-up observation was conducted of Resident 5 in his room. Resident 5 laid in bed with his eyes closed, his upper extremities were exposed and no hand mittens noted. On 8/12/25 at 2:23 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 5 was confused. CNA 1 stated when Resident 5 was admitted, he had the hand mittens because he kept grabbing his urinary catheter while in the hospital. CNA 1 stated Resident 5 did not exhibit the behavior of pulling his urinary catheter during his stay at the facility. On 8/12/25 at 3:15 P.M., a concurrent review of Resident 5's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 reviewed Resident 5's document titled TAR, dated July 2025. LN 1 stated the LNs signed off Resident 5 had the hand mittens every shift except on hygiene. LN 1 stated Resident 5 was completely confused. LN 1 stated Resident 5 came to the facility with hand mittens on him per Resident 5's family member (FM) request. LN 1 stated Resident 5's FM informed the facility Resident 5 needed the hand mittens to prevent him from pulling his urinary catheter. LN 1 stated the admitting nurse was responsible for assessing the residents when the residents were admitted to the facility. LN 1 stated there was no assessment done prior to the use of hand mittens for Resident 5. On 8/12/25 at 4:21 P.M., a concurrent review of Resident 5's clinical record and an interview was conducted with MDS Nurse (MDSN). The MDSN stated Resident 5 came with hand mittens and she coded Resident 5 with limb restraint in the MDS tool. The MDSN stated Resident 5 had a history of scratching his face in the hospital. The MDSN reviewed Resident 5's Medication Record and stated the LNs were signing the hand mittens were in placed and indicated as used, from 7/7/25 to 7/25/25. The MDSN stated, There was only a statement in the admission notes, and no assessment was done for Resident 5's hand mittens. The MDSN also stated there was no progress notes related to Resident 5's hand mittens in the LNs weekly notes. The MDSN stated there was no assessment on the use of the hand mittens prior to its use, and there was no assessment if Resident 5 still needed the hand mittens. The MDSN stated the purpose of the assessment was to determine the appropriateness of the use of restraint and if less restrictive interventions or measures could be used if warranted. The MDSN stated the hand mittens used for Resident 5 should have been addressed earlier if he was assessed earlier. The MDSN stated anything that physically inhibited the resident's movement was considered restraint. On 8/14/25 at 1:07 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the expectation was for the LNs to have assessed Resident 5's needs for the use of the hand mittens and to identify less restrictive options to prevent unnecessary use of restraint. Per the facility's policy, titled Comprehensive Assessments, revised 3/22, . Comprehensive Assessments are conducted to assist in developing person-centered care plans.2. admission Assessment - The admission assessment is a comprehensive assessment for a new resident. Per the facility's policy, titled Use of Restraint, revised 4/17, .Restraints shall only be used for the safety and well-being of the residents and after other alternatives have been tried unsuccessfully.When the use of restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.6. Prior to placing a resident in restraints, there shall be a pre- restraining assessment and review to determine the needs of restraints.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standards of practice when a Licensed Nurse (LN) did not follow physician's order/instructions during medication administration observation. This failure had the potential to cause side effects for Resident 38's health condition. Findings: Per the facility's admission Record, Resident 38 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (a condition wherein stomach contents leak backwards). A review of Resident 38's minimum data set (MDS- a federally mandated assessment tool) dated 8/4/25 indicated, Resident 38's brief interview for mental status (BIMS) was 3 which meant Resident 38's cognition (thought process) was severely impaired. On 8/13/25 at 8:46 A.M., an observation of medication administration to Resident 38 and an interview was conducted with LN 11. Resident 38's medication pack on Amantadine (Parkinson medication) indicated, to be given with food. LN 11 administered Resident 38's Amantadine without offering food to Resident 38. LN 11 stated she should have given Resident 38 some food like applesauce with the medication as ordered by Resident 38's physician. A record review of the physician's order dated 7/31/25 indicated, Amantadine was to be given by mouth with breakfast and lunch. On 8/13/25 at 9 A.M., an interview with Resident 38 was conducted. Resident 38 stated she was not sure if she had eaten her breakfast and that she took her medication from the nurse. On 8/14/25 at 10:30 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated licensed nurses are expected to follow physician's orders and instructions of the medications to prevent possible side effects and or complications like gastric upset with medications that had to be given with meals. A review of the facility's policy titled, Administering Medications, dated April 2019 indicated, .7. Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure food and nutrition services staff was knowledgeable to safely and effectively carry out the functions of the department, when one [NAME] (CK 1) incorrectly demonstrated how to calibrate a food thermometer. This failure in staff competence could lead to incorrect food temperature, which could increase the risk of foodborne illness in the resident population of 47. Findings: On 8/14/25 at 9:05 A.M., an observation of CK 1 calibrating the food thermometer, with the presence of the Registered Dietitian (RD), the Food Service Director (FSD), and the Executive Chef (EC) and an interview was conducted with CK 1. CK 1 put some ice into a metal bin then put a little bit of sink water into it. CK 1 immersed the food thermometer into the metal bin with the probe touching the bottom of the metal bin. CK 1 stated that was how they were trained to calibrate the food thermometer. On 8/14/25 at 9:40 A.M., an interview was conducted with the FSD. The FSD stated per the facility's policy, CK 1 should have used a small cup or container with ice and put water to the top of the container then submerge the thermometer. The FSD stated it was important to calibrate the food thermometer right to get the right temperature. On 8/14/25 at 9:42 A.M., an interview was conducted with the RD. The RD stated the proper technique to calibrate the food thermometer was to fill a cup with ice and fill up with water to the top. The RD stated the calibration of the food thermometer was important to get the right temperature of the food and the food was safe to consume. A review of the facility's policy, titled Thermometers and Measuring Temperature, dated 10/1/22, indicated, .Verifying thermometer calibration, Fill a cup of or small container with ice, Add cold water to the top of the container, insert thermometer probe into the ice water.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary measures were met in the kitchen during dietary operations according to standards of practice when a Dietary Aide (DA) 2 was not wearing a hair net while sorting the food utensils in the food cart. This finding had the potential for food contamination and exposed the facility's residents to unsafe and unsanitary food practices that could lead to widespread food borne illnesses. Findings: On 8/11/25 at 8:10 A.M., an observation of the kitchen was conducted with DA 1. In the clean area, DA 2 was noted sorting out food utensils and folding some papers in the food cart without a hair net. DA 1 gestured DA 2 to wear a hair net. DA 1 stated the expectation for the kitchen staff were to wear a hair net when entering the kitchen to prevent hair from contaminating the food. On 8/11/25 at 9:05 A.M., an interview was conducted with DA 2. DA 2 stated she was folding some paper and was putting food utensils in the food cart. DA 2 stated she forgot to wear a hair net. DA 2 stated it was important to wear a hair net all the time in the kitchen because hair could go to the food and contaminate the food. On 8/11/25 at 3:30 P.M., an interview was conducted with the Registered Dietitian (RD). The RD stated the expectation for kitchen staff was to wear a hair net in the kitchen all the time, so the hair was covered to prevent food contamination. According to the 2017 Federal Food and Drug Administration (FDA) Food Code, Title 21, Sections 110.10 Personnel .(6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps.or other effective hair restraints . A review of the facility's policy titled, Uniform Dress Code, revised 1/25, indicated, .Associates Working with Food: Wear the approved hair restraint when on duty regardless of length or presence of hair .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Redwood Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 W 13th 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 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** Based on observation, interview, and record review, the facility failed to follow their own policy or guidance regarding Enhanced Barrier Precautions (EBP- an infection control strategy that uses gown and gloves during high contact resident care like medication administration to residents with pressure ulcer [injury to the skin and underlying tissue]), when a licensed nurse entered an EBP room without performing hand hygiene (handwashing or alcohol based handrub) and donning personal protective equipment (PPE-such as the use of gloves, gown, mask). As a result, there was a potential for cross contamination and spread of infection. Findings: Per the facility's admission Record, Resident 66 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer (injury to the skin and underlying tissue) of the sacral region, stage 3 (full thickness skin and tissue loss). On 8/13/25 at 8:36 A.M., an observation of medication administration for Resident 66 was conducted with Licensed Nurse (LN) 11. A signage was posted in Resident 66's room indicating he was on EBP. LN 11 prepared Resident 66's medication and entered Resident 66 room without PPE. LN 11 administered Resident 66's enoxaparin (anticoagulant) and injected subcutaneously (under the skin). LN 11 exited the room without performing hand hygiene before and after medication administration. On 8/13/25 at 8:45 A.M., an interview with LN 11 was conducted. LN 11 stated Resident 66 was on EBP. LN 11 stated she did not wear PPE like gown and gloves while administering medication to Resident 66. LN 11 stated it was important to use PPE to prevent the spread of infection to other residents. On 8/14/25 at 1:13 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was important for facility staff to perform hand hygiene before and after resident care and put on PPE to prevent the spread of infection to all residents. A review of the facility's undated guidance on enhanced barrier precaution indicated, .25. EBP should be followed when performing.close physical contact.Hand hygiene is recommended before and after resident contact.		