

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Palomar Heights Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E Ohio Avenue Escondido, CA 92027	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235</p> <p>Based on observation, interview, and record review the facility failed to provide care and services according to professional standards of practice to one (Resident 6) of four residents reviewed for quality of care when:</p> <ol style="list-style-type: none"> 1. The facility did not assess Resident 6's change in condition and, 2. The facility did not notify the physician of Resident 6's change in condition. <p>As a result, the physician was not aware of Resident 6's change of condition and Resident 6 expired.</p> <p>Findings:</p> <p>Resident 6 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (a condition in which the heart does not pump or fill blood as well as it should) and ischemic cardiomyopathy (damaged heart muscle from lack of blood flow) according to the facility's Admission Record.</p> <p>During a review of progress notes (PN) written by the assigned night shift nurse for Resident 6 dated [DATE] at 5:20 A.M., the PN indicated the certified nurse assistant (CNA) reported to the charge nurse that resident was not responding. The PN indicated cardiopulmonary resuscitation (CPR-a lifesaving technique used when someone's heart was not beating) was initiated for Resident 6 and 911 (emergency telephone number) was called. The PN further indicated, Paramedics arrived after 5 minutes after the call was made. Paramedics pronounced resident expired.</p> <p>An interview was conducted on [DATE] at 2:50 P.M., with certified nurse assistant (CNA) 3. CNA 3 stated she was assigned to Resident 6 on [DATE], night shift which started at 10:30 P.M. until 7 A.M. CNA 3 stated during rounds at approximately 4 A.M. to 5 A.M., she found Resident 6 unresponsive. CNA 3 stated she called out, Hello, hello, then shook Resident 6, but did not wake up. CNA 3 stated she notified licensed nurse (LN) 4 right away. CNA 3 further stated Resident 6 was asleep when she checked Resident 6 at 10:30 P.M., 12 A.M., and at 2 A.M.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted on [DATE] at 1:52 P.M., with LN 3. LN 3 stated he was assigned to Resident 6 on [DATE], night shift which started at 11 P.M. LN 3 stated there was no report of any change in condition from the afternoon LN regarding Resident 6. LN 3 stated he saw Resident 6 at approximately 12 A.M. to 1 A.M. and Resident 6 was sitting up at the edge of his bed, watching TV without any changes. LN 3 stated at approximately 5 A.M., the CNA notified him that Resident 6 was unresponsive. LN 3 stated he ran to the room and called another LN. LN 3 stated he and the other LN placed Resident 6 on the floor and initiated CPR until the paramedics (health care professionals who responds to emergency calls) arrived.</p> <p>An interview was conducted on [DATE] at 2:06 P.M., with LN 4. LN 4 stated he was assigned to Resident 6 on [DATE] 2:30 P.M. until 11 P.M. LN 4 stated CNA 6 notified him at around 9:30 P.M. to 10 P.M. that Resident 6 refused to take a shower because Resident 6 was not feeling well. LN 4 stated he requested for Resident 6's vital signs (VS- temperature, heart rate, breathing), but CNA 6 did not provide Resident 6's VS. LN 4 stated he did not follow up to take Resident 6's VS or check on Resident 6's condition because he was busy. LN 4 was asked when he would check on a resident and replied, It depended on the needs of the resident. If there was a change in condition it would be a priority.</p> <p>During an interview on [DATE] at 2:57 P.M., with CNA 6, CNA 6 stated she worked on the [DATE] afternoon shift and was assigned to provide a shower for Resident 6. CNA 6 stated CNA 3 was assigned to Resident 6 for the afternoon shift. CNA 6 stated Resident 6 was offered a shower at 3:30 P.M. and Resident 6 refused because he was not feeling well. CNA 6 stated Resident 6 requested to return later. CNA 6 stated she offered a shower again to Resident 6 at 4:30 P.M., and Resident 6 stated he still did not feel well and looked pale and sweaty. CNA 6 stated she reported to LN 4 that Resident 6 refused shower and did not feel well. CNA 6 stated LN 4 instructed her to have the assigned CNA take Resident 6's VS. CNA 6 stated LN 4 got upset because CNA 3 brought the VS machine to LN 4 with Resident 6's VS instead of writing them on a piece of paper. After dinner, CNA 6 stated she offered the shower to Resident 6 again with CNA 3 as the witness, but Resident 6 was still pale and sweaty. CNA 6 stated she notified LN 4 again and LN 4 asked how Resident 6 looked. CNA 6 stated she reported that Resident 6 looked like he had flu symptoms. CNA 6 further stated LN 4 did not check on Resident 6.</p> <p>During a review of Weights and Vitals Summary for Resident 6, there was no documentation of Resident 6's temperature and respirations on [DATE] afternoon shift.</p> <p>An interview was conducted on [DATE] at 3:50 P.M., with the director of nurses (DON). The DON confirmed CNA 3 was assigned to Resident 7 on [DATE] afternoon shift. The DON stated if she was the licensed nurse and a CNA did not take a resident's VS per her instruction, she then would take the VS herself and complete an assessment prior to physician notification.</p> <p>An interview was conducted on [DATE] at 3:06 P.M., with LN 7 regarding a resident's change in condition. LN 7 stated she would assess the resident, take the resident's VS, and notify the physician.</p> <p>The facility's director of staff development (DSD- a licensed nurse certified for staff training) was interviewed on [DATE] at 3:14 P.M. The DSD stated she had conducted an in-service for the facility's licensed nurses regarding resident change in condition. The DSD stated licensed nurses were taught to complete the e-Interact (Interventions to Reduce Acute Care Transfers- an electronic quality improvement program designed to improve identification, evaluation, and communication about changes in resident status) form which triggered staff to notify the physician. The DSD further stated assessment of a resident with a change in condition should be performed prior to physician notification.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of an In-service Attendance Record, dated [DATE] titled, COC (change of condition) documentation and Processes ., the in-service attendance record did not have LN 4's signature under Attendance.</p> <p>Resident 6's physician was interviewed on [DATE] at 9 A.M. The physician stated Resident 6 had diagnoses including CHF, ischemic cardiomyopathy, and a history of myocardial infarction (MI- a heart attack). The physician stated he was not aware that Resident 6 had symptoms of sweating and being pale. The physician stated symptoms of being sweaty and pale were signs of ischemia (lack of blood flow to a part of the body). The physician further stated he expected the facility staff to assess (evaluate) Resident 6 and to notify him of the change in condition.</p> <p>A review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider .</p>		