STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555764	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Heights Post Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to prevent Resident 1 from falling while transferring from bed to a wheelchair with nonfunctioning brakes. This failure had the potential to cause injury due to unnecessary falls caused by nonfunctioning brakes on Resident 1 ' s wheelchair. Cross Reference F908 Findings: Review of Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included acquired absence of left leg below the knee, difficulty in walking, and unspecified glaucoma (chronic eye disease that occurs when fluid builds up in the eye, damaging the optic nerve and causing vision loss or blindness). Review of History and Physical dated 12/11/23 indicated, .She is limited by a left BKA (Below the knee amputation-surgical removal of leg below the knee .Bed mobility: Independent, Transfer: Independent, Dressing: Independent .Orientation to time, place, and person: Patient appears moderately disoriented . Review of MDS section C-Cognitive Patterns dated 8/2/24 indicated a Brief Interview for Mental Status (BIMs-Test used by nursing homes to indicate cognitive ability) as 13 out of 15 indicating intact cognitive abilities. Review of MDS section GG-Functional Abilities and Goals dated 8/2/24 indicated Chair/bed to chair transfer was coded as Supervision or touching assistance-Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 a concurrent observation and interview with Resident 1 was conducted with CNA 1 acting as the Spanish translator. Resident 1 was observed sitting in her wheelchair watching television. Resident 1 was observed to have a left BKA without a prosthesis (artificial device that replaces a missing body part). Resident 1 was alert and oriented, but was hard of hearing (HOH) and needed a Spanish translator. Resident 1 stated that on 9/21/24 at about 7 P.M., she was transferring from bed to the wheelchair, but the wheelchair moved as she moved toward it despite brakes being locked, and she fell to the floor. Resident 1 stated that she was asking for help, but no one came for about 1/2 hour, when her roommate ' s grandson had come into the room. Resident 1 stated that she normally transfers by herself without a problem. Resident 1 stated that she bumped her elbows. Resident 1 stated no one had fixed the brakes on her wheelchair, and that they were still broken. During the interview, Resident 1 ' s wheelchair brakes were observed. With Resident 1 ' s permission, both of the wheelchair ' s wheels were fully locked and slight pressure was applied on the wheels. Both wheels were observed to move. Resident 1 stated that this was the same wheelchair she used when she had fallen. On 9/25/24 at 1:20 P.M., a concurrent interview with CNA 1 and observation of Resident 1 ' s wheelchair was conducted. CNA 1 stated that both wheels of Resident 1 ' s wheelchair were able to move even with brakes fully engaged. CNA 1 stated that the expectation is that the wheelchair ' s brakes should stop the wheelchair from moving. CNA 1 stated the importance of functions wheelchair brakes was to prevent falls and to keep the residents safe. On 9/25/24 at 1:25 P.M, a concurrent interview of CNA 1 and record review of Maintenance Log was conducted. CNA 1 stated the process for reporting broken equipment was to page the Director of Maintenance (DOM) to the nursing unit to tell them about the broken equipment, and to write the problem in the maintenance log at the nursing station. Review of the maintenance log indicated that Resident 1 ' s wheelchair brakes were not reported as broken. On 9/25/24 at 1:35 P.M., a concurrent observation of Resident 1 ' s wheelchair, interview with the DOM, and record review of the maintenance log was conducted. The DOM stated that the facility provided Resident 1 with her wheelchair. The DOM stated that he checks the wheelchair brakes if problem is reported but did not provide regular maintenance of wheelchair brakes for any of the residents ' wheelchairs. Resident 1 ' s nonfunctioning wheelchair brakes were observed with the DOM. The DOM stated that both wheels of Resident 1 ' s wheelchair were able to move with brakes fully engaged. The DOM stated that the expectation is that wheelchair brakes should fully stop the movement of the wheelchair ' s wheels. The DOM stated the importance of functioning wheelchair brakes is for resident safety and fall prevention. The DOM stated he checked the maintenance book ever day at nursing station. Record review of the maintenance book with the DOM was conducted, and no documentation of Resident 1 ' s wheelchair brakes were not reported despite Resident 1 having a fall related to the wheelchair. On 9/25/24 at 1:50 P.M., an interview with CNA 2 and observation of Resident 1 ' s wheelchair was conducted. CNA 2 stated that the wheels on the wheelchair were still moving when the brakes were fully engaged. CNA 2 stated that the expectation for wheelchairs is that their brakes should stop the wheels from moving. CNA 2 stated the importance of functioning wheelchair brakes is to prevent motion when the resident is transferring to the wheelchair and patient safety. CNA 2 stated that the process for reporting broken equipment was to notify the DOM and log the broken equipment in the maintenance book. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 2:05 P.M., an interview with LN 3 and observation of Resident 1 ' s wheelchair was conducted. LN 3 stated that the wheels on the wheelchair were still moving when the brakes were fully engaged. LN 3 stated the expectation is that a wheelchair ' s brakes will prevent the wheelchair from moving. LN 3 stated the importance of functioning wheelchair brakes was patient safety, especially when resident is transferring to the wheelchair. LN 3 stated that the process for reporting broken equipment was to notify the DOM and then to log the broken equipment in the maintenance log. On 9/25/24 at 2:20 P.M., an interview of the Director of Nursing (DON)and observation of Resident 1 ' s wheelchair were conducted. The DON stated the wheels on the wheelchair were still moving when the brakes were fully engaged. The DON stated the expectation is that a wheelchair ' s brakes should prevent movement of the wheels. The DON stated that the importance of functioning wheelchair brakes is to for resident safety and to prevent resident falls. The DON stated that the expectation is wheelchairs should be maintained by the facility on a regular basis. The DON stated that importance of equipment maintenance is resident safety. On 9/25/24 at 3:42 P.M., a telephone interview was conducted with LN 1, the nurse who found Resident 1 after she had fallen. LN 1 stated that Resident 1 ' s fall was unwitnessed, but he was the first staff to help her. LN 1 stated that when he found her, she was sitting on the floor. LN 1 stated he helped Resident 1 back to bed, and he did a full body assessment on her, contacted her responsible party (RP), and the covering physician. LN 1 stated that Resident 1 had some soreness in her elbows on assessment, but there was no major injury assessed. LN 1 stated medical doctor (MD) orders were to monitor Resident 1. LN 1 stated that he was not aware that Resident 1 ' s wheelchair brakes were not functioning, and that if he had known he would have notified the DOM to fix the brakes or get a new wheelchair. LN 1 stated he would have written the wheelchair ' s problem in the maintenance book. LN 1 stated that the expectation is that wheelchair brakes should prevent the wheels from moving. LN 1 stated the importance of functioning brakes is to prevent the wheels from moving when resident is transferring. Review of Change in Condition note dated 8/21/24 at 7:15 P.M. indicated .Patient sitting on the floor. No s/s [signs and symptoms] of pain or discomfort. No injury noted at this time. Encouraged to use call light to transfer. Review of Interdisciplinary Team (IDT) Note dated 8/22/24 indicated that .Resident with an unwitnessed fall in room on 8/21/24 at about 1800 [6 P.M.] Resident was attempting a self-transfer OOB [Out of bed] to WC[wheelchair, when she lost balance and fell between WC and bed. No injuries from fall .Risk factors .Altered mental status, visual impairment, hearing impairment, unsteady gait, altered Balance while standing and/or walking, decrease muscle coordination . IDT note did not indicate any inspection or repair of Resident 1 ' wheelchair after the unwitnessed fall. Review of care plan dated 8/21/24 indicated Focus, -Falls: Resident had an unwitnessed fall and is at risk for recurring falls .Goal- .Will minimize risk for additional falls to the extent possible .Interventions/Tasks . Anticipate and meet needs . There was no intervention about ensuring the wheelchair brakes are locked and effectively functioning. (continued on next page)

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Palomar Heights Post Acute	1260 E Ohio Avenue Escondido, CA 92027

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Maintenance Request log from 3/3/24 to 9/25/24 indicated no reported problems with wheelchairs, except for day of onsite visit when nonfunctioning brakes were reported to the CNA. Review of Wheelchair Cleaning Schedule from May thru July 2024 indicated that there was no documentation of Resident 1 ' s wheelchair needing or having repair. Review of the facility policy titled FALL AND FALL RISK, MANAGING dated March 2018 indicated .A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .Fall Risk Factors .1. e. improperly fitted or maintained wheelchairs . Review of facility policy titled ASSISTIVE DEVICES AND EQUIPMENT dated 2001 indicated Our facility maintains and supervises the use of assistive devices and equipment for residents .6. The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment .c. Device condition-devices and equipment are maintained on schedule and according to manufacturer ' s instructions. Defective or worn devices are discarded or repaired .

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to ensure a medical equipment (wheelchair) was maintained in good, proper condition on one of one resident (Resident 1) reviewed for medical equipment. As a result, Resident 1 fell due to the wheelchair's brakes not functioning. Cross Reference F689 Findings: Review of Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included: Acquired absence of left leg below the knee, difficulty in walking, and unspecified glaucoma (chronic eye disease that occurs when fluid builds up in the eye, damaging the optic nerve and causing vision loss or blindness). Review of History and Physical dated 12/11/23 indicated, .She is limited by a left BKA (Below the knee amputation-surgical removal of leg below the knee .Bed mobility: Independent, Transfer: Independent, Dressing: Independent .Orientation to time, place, and person: Patient appears moderately disoriented . Review of MDS section C-Cognitive Patterns dated 8/2/24 indicated a Brief Interview for Mental Status (BIMs-Test used by nursing homes to indicate cognitive ability) as 13 out of 15 indicating intact cognitive abilities. Review of MDS section GG-Functional Abilities and Goals dated 8/2/24 indicated Chair/bed to chair transfer was coded as Supervision or touching assistance-Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. On 9/25/24 a concurrent observation and interview with Resident 1 was conducted with CNA 1 acting as the Spanish translator. Resident 1 was observed sitting in her wheelchair watching tv. Resident 1 was observed to have a left BKA without a prosthesis. Resident 1 was alert and oriented, but was hard of hearing (HOH) and needed a Spanish translator. Resident 1 stated that on 9/21/24 at about 7 P.M., she was transferring from bed to the wheelchair, but the wheelchair moved as she moved toward it despite brakes being locked, and she fell to the floor. Resident 1 stated that she was asking for help, but no one came for about 1/2 hour, when her roommate ' s grandson had come into the room. Resident 1 stated that she normally transfers by herself without a problem. Resident 1 stated that she bumped her elbows, but she was feeling better. Resident 1 stated no one had fixed the brakes on her wheelchair, and that they were still broken. During the interview, Resident 1 ' s wheelchair brakes were observed. With Resident 1 ' s permission, both the of the wheelchair ' s wheels were fully locked and slight pressure was applied on the wheels. Both wheels were observed to move. Resident 1 stated that this was the same wheelchair she was using when she had fallen. (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 1:20 P.M., a concurrent interview with CNA 1 and observation of Resident 1 ' s wheelchair was conducted. CNA 1 stated that both wheels of Resident 1 ' s wheelchair were able to move with brakes fully engaged. CNA 1 stated that the expectation is that the wheelchair ' s brakes should stop the wheelchair from moving. CNA 1 stated the importance of functions wheelchair brakes was to prevent falls and to keep the residents safe. On 9/25/24 at 1:25 P.M, a concurrent interview of CNA 1 and record review of Maintenance Log was conducted. CNA 1 stated the process for reporting broken equipment was to page the Director of Maintenance (DOM) to the nursing unit to tell them about the broken equipment, and to write the problem in the maintenance log at the nursing station. Review of the maintenance log indicated that Resident 1 ' s wheelchair brakes were not reported as broken. CNA 1 entered the wheelchair brakes into the log. On 9/25/24 at 1:35 P.M., a concurrent observation of Resident 1 ' s wheelchair, interview with the DOM, and record review of the maintenance log was conducted. The DOM stated that the facility provided Resident 1 with her wheelchair. The DOM stated that he checks the wheelchair brakes if problem is reported but did not provide regular maintenance of wheelchair brakes for any of the residents ' wheelchairs. Resident 1 ' s nonfunctioning wheelchair brakes were observed with the DOM. The DOM stated that both wheels of Resident 1 ' s wheelchair were able to move with brakes fully engaged. The DOM stated that the expectation is that wheelchair brakes should fully stop the movement of the wheelchair ' s wheels. The DOM stated the importance of functioning wheelchair brakes is for resident safety and fall prevention. The DOM stated he checked the maintenance book ever day at nursing station. Record review of the maintenance book with the DOM was conducted, and no documentation of Resident 1 ' s wheelchair brakes were not reported despite Resident 1 having a fall related to the wheelchair. On 9/25/24 at 1:50 P.M., an interview with CNA 2 and observation of Resident 1 ' s wheelchair was conducted. CNA 2 stated that the wheels on the wheelchair were still moving when the brakes were fully engaged. CNA 2 stated that the expectation for wheelchairs is that their brakes should stop the wheels from moving. CNA 2 stated the importance of functioning wheelchair brakes is to prevent motion when the resident is transferring to the wheelchair and patient safety. CNA 2 stated that the process for reporting broken equipment was to notify the DOM and log the broken equipment in the maintenance book. On 9/25/24 at 2:05 P.M., an interview with LN 3 and observation of Resident 1 ' s wheelchair was conducted. LN 3 stated that the wheels on the wheelchair were still moving when the brakes were fully engaged. LN 3 stated the expectation is that a wheelchair ' s brakes will prevent the wheelchair from moving. LN 3 stated the importance of functioning wheelchair brakes was patient safety, especially when resident is transferring to the wheelchair. LN 3 stated that the process for reporting broken equipment was to notify the DOM and then to log the broken equipment in the maintenance log. On 9/25/24 at 2:20 P.M., an interview of the Director of Nursing (DON)and observation of Resident 1 ' s wheelchair were conducted. The DON stated the wheels on the wheelchair were still moving when the brakes were fully engaged. The DON stated the expectation is that a wheelchair ' s brakes should prevent movement of the wheels. The DON stated that the importance of functioning wheelchair brakes is to for resident safety and to prevent resident falls. The DON stated that the expectation is wheelchairs should be maintained by the facility on a regular basis. The DON stated that importance of equipment maintenance is resident safety. (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 3:42 P.M., a phone interview was conducted with LN 1, the nurse who found Resident 1 after she had fallen. LN 1 stated that Resident 1 ' s fall was unwitnessed, but he was the first staff to help her. LN 1 stated that when he found her, she was sitting on the floor. LN 1 stated he helped Resident 1 back to bed, and he did a full body assessment on her, contacted her responsible party (RP), and the covering physician. LN 1 stated that Resident 1 had some soreness in her elbows on assessment, but there was no major injury assessed. LN 1 stated MD orders were to monitor Resident 1. LN 1 stated that he was not aware that Resident 1 ' s wheelchair brakes were not functioning, and that if he had known he would have notified the DOM to fix the brakes or get a new wheelchair. LN 1 stated he would have written the wheelchair ' s problem in the maintenance book. LN 1 stated that the expectation is that wheelchair brakes should prevent the wheels from moving. LN 1 stated the importance of functioning brakes is to prevent the wheels from moving when resident is transferring. Review of Change in Condition note dated 8/21/24 at 7:15 P.M. indicated .Patient sitting on the floor. No s/s [signs and symptoms] of pain or discomfort. No injury noted at this time. Encouraged to use call light to transfer. Review of Interdisciplinary Team (IDT) Note dated 8/22/24 indicated that .Resident with an unwitnessed fall in room on 8/21/24 at about 1800[6 P.M.] Resident was attempting a self-transfer OOB[Out of bed] to WC[wheelchair, when she lost balance and fell between WC and bed. No injuries from fall .Risk factors . Altered mental status, visual impairment, hearing impairment, unsteady gait, altered Balance while standing and/or walking, decrease muscle coordination . IDT note did not indicate any inspection or repair of Resident 1 ' wheelchair after the unwitnessed fall. Review of care plan dated 8/21/24 indicated Focus, -Falls: Resident had an unwitnessed fall and is at risk for recurring falls .Goal- .Will minimize risk for additional falls to the extent possible .Interventions/Tasks . Anticipate and meet needs . There was no intervention about ensuring the wheelchair brakes are locked and effectively functioning. Review of Maintenance Request log from 3/3/24 to 9/25/24 indicated no reported problems with wheelchairs, except for day of onsite visit when nonfunctioning brakes were reported to the CNA. Review of Wheelchair Cleaning Schedule from May thru July 2024 indicated that there was no documentation of Resident 1 ' s wheelchair needing or having repair. Review of the facility policy titled FALL AND FALL RISK, MANAGING dated March 2018 indicated .A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .Fall Risk Factors .1. e. improperly fitted or maintained wheelchairs . Review of facility policy titled ASSISTIVE DEVICES AND EQUIPMENT dated 2001 indicated Our facility maintains and supervises the use of assistive devices and equipment for residents .6. The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment .c. Device condition-devices and equipment are maintained on schedule and according to manufacturer ' s instructions. Defective or worn devices are discarded or repaired .