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	02/17/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were not left unattended at Resident 1's bedside table for 1 out of 3 sampled residents reviewed for medication administration. This failure had the potential to place residents at risk for ingestion of the medications. Findings.An unannounced visit to the facility was conducted on 2/17/26 relative to an anonymous complaint regarding the quality of care the facility provides. A review of the facility's undated admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included encounter attention to gastrostomy (a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids and medication) and seizures (a sudden uncontrolled surge of electrical activity in the brain). During a tour of the facility on 2/17/26 at 10:15 A.M., Resident 1 was observed lying in bed with his eyes closed. A clear plastic cup was observed with medications crushed mixed in a tea colored liquid on Resident 1's bedside table. A review of Resident 1's minimum data set (MDS - a federally mandated assessment tool) dated 1/7/26 indicated Resident 1's brief interview for mental status (BIMS) cognition- (thought process) was blank. A review of Resident 1's physician orders dated 6/16/24 indicated Resident 1 was on the following medications:Ascorbic acid (Vitamin C) tablet 500 mg (unit of measurement), give 1 tablet via g-tube in the morning for immune support.Furosemide oral tablet 40 mg, give 1 tablet via g-tube in the morning for diuretic. Hold dose if systolic blood pressure -top number in a reading) sbp <100. Multivitamin with minerals oral tablet (multiple vitamins with minerals), give 1 tablet via g-tube in the morning for dietary supplement. A review of the Medication Administration Record (MAR) dated 2/17/26 indicated the above medications were administered and signed off by the licensed nurse (LN) as being given. On 2/17/26 at 11 A.M., an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated she left Resident 1's medications on Resident 1's bedside table to further dissolve in water. LN 1 stated she should not have left the medications in a clear cup on Resident 1's bedside table for safety, since some residents or someone might picked up the medications, take them and swallow them. On 2/17/26 at 11:15 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated medications should not be left anywhere in any resident rooms unattended. The DON stated it was important to not leave medications unattended for residents' safety . A review of the facility's policy titled, Storage of Medications dated April 2007 indicated, #2.The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. #7. Compartments (including but not limited to drawers, cabinets, rooms,) containing biologicals shall be locked when not in use.items shall not be left unattended .

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
	555764	A. Building B. Wing	02/17/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview and record review, the facility failed to maintain accurate documentation for one of three sampled residents (Resident 1). when Resident 1's medication left unattended at Resident 1's bedside was documented as being given. This failure created inaccurate information which could affect Resident 1's plan of care. Findings. An unannounced visit to the facility was conducted on 2/17/26 relative to an anonymous complaint regarding the quality of care the facility provides. A review of the facility's undated admission record indicated resident 1 was admitted to the facility on [DATE] with diagnoses that included encounter attention to gastrostomy (GT- a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids and medication) and seizures (a sudden uncontrolled surge of electrical activity in the brain). During a tour of the facility on 2/17/26 at 10:15 A.M., Resident 1 was observed lying in bed with his eyes closed. A clear plastic cup was observed with medications crushed mixed in a tea-colored liquid on Resident 1's bedside table. A review of Resident 1's minimum data set (MDS - a federally mandated assessment tool) dated 1/7/26 indicated Resident 1's brief interview for mental status (BIMS) cognition- (thought process) was blank. A review of Resident 1's physician orders dated 6/16/2024 indicated Resident 1 was on the following medications.Ascorbic acid (Vitamin C) tablet 500 mg (unit of measurement), give 1 tablet via g-tube in the morning for immune support.Furosemide oral tablet 40 mg , give 1 tablet via g-tube in the morning for diuretic. hold dose if systolic blood pressure -top number in a reading) sbp <100.Multivitamin with minerals oral tablet(multiple vitamins with minerals) , give 1 tablet via g-tube in the morning for dietary supplement. A review of the Medication Administration Record (MAR) dated 2/17/25 at 9 A.M. indicated the above medications were administered and signed off by the licensed nurse (LN) as being given. On 2/17/26 at 11 A.M., an interview with the Licensed Nurse (LN) 1 was conducted. LN 1 stated she left Resident 1's medications on Resident 1's bedside table to further dissolve in water she had administered earlier and had already documented in the MAR. On 2/17/26 at 11:15 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated medications should not be left anywhere in any resident rooms unattended. The DON stated LN 1 had documented in the MAR she had administered Resident 1's medications via GT. A review of the facility's policy titled Administering Medications dated April 2029 , indicated Policy & Implementation #1. Only licensed or permitted by the state to prepare, administer and document the administration of medications.#4. Medications are administered in accordance with prescribers orders . #21. If a drug is withheld, refused , or given at a time other than the scheduled time, the individual administering the medication .