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	05/21/2026

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 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** Based on observation, interview and record review, the facility failed to implement a 30-minute visual monitoring intervention for one sampled resident (1) reviewed for elopement and wandering after the resident previously eloped from the facility. As a result, Resident 1 was placed at increased risk of another potential elopement.Resident 1 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (a chronic mental health condition with symptoms of hallucinations, delusions and mood alterations) per the facility admission record. A review of the facility's elopement and wandering risk assessment, dated 4/10/26, indicated Resident 1 was assessed as at risk for wandering or elopement. A review of the facility's progress notes for Resident 1 indicated Resident 1 eloped from the facility on 4/16/26 sometime around 8:00 P.M. and returned to the facility the next morning on 4/17/26 at 8:45 A.M. During an observation on 4/21/26 at 2:20 P.M., Resident 1 was sitting in his wheelchair in his room near the door with multiple packed bags sitting at the foot of the bed. A binder titled, Visual observation, Q-30 minutes was labeled with Resident 1's room number and was placed on the handrail directly outside Resident 1's door. During an interview and record review on 4/21/26 at 2:32 P.M., certified nursing assistant (CNA) 1 stated he was Resident 1's CNA for the 7AM-3PM shift. CNA 1 stated Resident 1 needed to be supervised because the resident likes to leave and had previously eloped from the facility. CNA 1 stated staff was instructed to monitor and document Resident 1's whereabouts and activities every 30 minutes in Resident 1's visual observation binder (VOB). A review of Resident 1's VOB documentation for CNA 1's 7AM-3PM shift indicated CNA 1 made zero entries for the 30-minute intervals from 10:30 A.M. to 2:30 P.M. CNA 1 stated he got busy and did not fill out the 30-minute documentation for between 10:30 A.M. and 2:30 P.M. monitoring intervention. CNA 1 stated if the VOB documentation was not complete there was no way to know if anyone checked on the resident. Further review of the 30-minute visual monitoring forms in Resident 1's VOB indicated the forms included a space for the date, time, staff monitoring and the resident's activity and behavior for that period. The 30-minute visual monitoring forms in Resident 1's VOB indicated the facility had not documented monitoring entries for over two consecutive hours or more on the following dates and times: 4/17/26: 12 A.M.-2:30 A.M. (2.5 hours(hrs.), 9:30 A.M - 9:30 P.M. (12 hrs.)4/18/26: 12 A.M.-10:00 A.M (10 hrs.)4/20/26: 10 A.M. - 12 P.M. (2 hrs.) 5:30 P.M.-11:30 P.M. (6 hrs.)4/21/26: 12: A.M. - 6:30 A.M. (6.5 hrs.) 10:30 A.M.-2:30 P.M. (4 hrs.) During an interview on 4/21/26 at 2:50 P.M., licensed nurse (LN) 1 stated he was working on the evening of 4/16/26 when Resident 1 eloped from the facility. LN 1 stated Resident 1 was independent and ambulatory and was believed to have walked out of the facility unnoticed. LN 1 stated Resident 1's location should be monitored by CNA's every 30 minutes and documented in Resident 1's VOB. LN 1 stated the VOB should be filled out every 30 minutes and CNAs should not wait until the end of the shift to document because that would not be considered monitoring the resident every 30 minutes. LN 1 stated licensed nurses should be checking that CNA's fill out the VOB every 30 minutes at the end of each shift. During an interview and record review of Resident 1's VOB monitoring forms with the director of staff development (DSD) on 4/21/26 at 3:30 P.M., the DSD (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	acknowledged the missing 30-minute visual monitoring entries for Resident 1 from 4/17/26 through 4/21/26. The DSD stated facility were expected to fill out the monitoring forms and document Resident 1's activity every 30 minutes and should know the importance of completing the task right after each observation. During an interview and record review of Resident 1's VOB monitoring forms with the director of nursing (DON) on 4/21/26 at 3:30 P.M., the DSD acknowledged the missing 30-minute visual monitoring entries for Resident 1 from 4/17/26 through 4/21/26. The DON stated staff were expected to complete visual monitoring of Resident 1 and document in the VOB every 30 minutes. The DON stated it was not ok for staff to wait until the end of their shift to document. The DON stated he was disappointed to see that monitoring checks were not completed because it placed the resident's safety at risk. A review of Resident 1's care plan for elopement, revised 4/17/26, indicated, Focus. Resident is at risk for elopement/exit seeking/wandering related to mood or behavior disorders, psychotropic/mood altering medications. Interventions. Location/safety checks. until appropriate placement or safety risk is no longer identified. A review of the facility in-service titled, Elopement vs Wandering: Code Yellow, dated 4/17/26, given to all staff by the DSD indicated, . Objective: Staff will demonstrate understanding of wandering and elopement risks, identify residents at risk and correctly implement prevention strategies. in order to maintain resident safety. Course Content. 3. Prevention. Staff awareness. Supervision at all times (q30 rounds). 6. Post elopement Care. Documentation. 8. Conclusion. Prevention is everyone's job; Early intervention is key. A review of the facility policy titled, Wandering, Unsafe Resident, revised August 2014, indicated, Policy Statement: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.