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	05/30/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 6 sampled residents reviewed for resident dignity was provided care in a manner that promoted dignity and respect. (Resident 57) This deficient practice had the potential to intimidate and be disrespectful towards the resident. Findings: Resident 57 was admitted to the facility on [DATE] with diagnoses including dysphagia, orophangeal phase (mouth and/or throat swallowing problem) according to the facility's admission Record. During an observation on 5/27/25 at 8:25 A.M., Resident 57 was in bed with a breakfast tray on the overbed table. Two Certified Nurse Assistants (CNA) arrived and repositioned Resident 57 in a sitting position in bed. CNA 2 then fed Resident 57 while standing up next to Resident 57's bed. During a joint observation and interview on 5/27/25 at 8:33 A.M. with CNA 1, CNA 1 looked at CNA 2 feeding Resident 57 from Resident 57's doorway. CNA 1 stated while feeding a resident who was in bed, staff should sit on a chair to encourage the resident to eat. CNA 1 stated at times a resident cannot hear well, and staff should sit facing the resident. An interview on 5/27/25 at 9:07 A.M. was conducted with CNA 2. CNA 2 stated while feeding a resident, there should be a bib and sit at resident's eye level. CNA 2 stated she was taught to sit while feeding a resident but she did not sit while feeding Resident 57 because there was no chair available in the room. During an interview on 5/28/25 at 9:05 A.M. with the Director of Staff Development (DSD- a licensed nurse certified to conduct staff training), the DSD stated CNAs should be sitting at resident's eye level for resident's dignity. During an interview on 5/30/25 at A.M. with the Director of Nursing (DON), the DON stated for resident's dignity she expected staff to sit during feeding assistance. A review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated March 2022, the P&P indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity .not standing over residents while assisting them with meals.

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
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assist with or obtain an Advanced Directive (AD-a legal document that allows a person to specify their healthcare preferences in the event that residents become unable to make medical decisions for themselves due to illness, injury, or other circumstances) for two of 24 sampled residents (Residents 22 & 56). This deficient practice placed Residents 22 & 56 at risk for not having their medical treatment wishes known or followed during a health emergency. Findings: 1. A review of Resident 22's admission Record indicated Resident 22 was re-admitted to the facility on [DATE] with diagnoses which included a history of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and dementia (a progressive state of decline in mental abilities). On 5/29/25 at 3:12 P.M., an interview and record review was conducted with the Social Service Director (SSD). The SSD stated an AD was obtained upon admission and discussed with the interdisciplinary team (IDT) regarding an AD. The SSD stated Resident 22 did not have an AD but had a Physician Orders for Life Sustaining Treatment (POLST-It is a medical form that documents a patient's wishes regarding end-of-life care) in her clinical record. The SSD stated that she would look up a form about AD online and would print it out and give it to residents (facility residents) and give them the ombudsman's number to help them make an AD, Because they'll [facility residents] would need a witness. On 5/30/25 at 8:34 A.M., an interview and record review was conducted with the Admissions Coordinator (AC). The AC stated she was unable to find documented evidence if an AD for Resident 9 if it was requested, refused, discontinued, or offered. The AC stated Resident 9's son was the responsible party (RP) and only a CONSENT TO TREAT form was signed by Resident 9's son on 9/9/22 that did not include information to request or offer an AD. The AC stated it was important to ask facility residents (including Resident 9) and their RP's if they have an AD and to help complete their AD should they need assistance. The AD stated it was important because if a resident (including Resident 9) is unable to make their health care decisions themselves that their rights are still honored in the event of any emergent medical care needed because this was part of Resident's Right. On 5/30/25 at 3:11 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectations that resident's (facility residents) who have an AD should be part of their (facility residents) clinical chart. The DON stated it was important to know who would be responsible for a resident's health care decisions according to their AD and know how to provide care during emergent incidents because this was, Their (facility residents) rights. 2. A review of Resident 56's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of corneal ulcer (a wound on the surface of the eye) to left eye and blindness in the right eye. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated during admission, the admission nurse would check if the resident had an advance directive, if not it would be discussed at the resident's care conference. On 5/30/25 at 8:19 A.M., an interview was conducted with the admission Director (AD). The AD stated she did not have an Advance Directive document for Resident 56. The AD stated Resident 56 signed the admission agreement, but there was no documentation an advance directive was offered, accepted, or declined. The AD stated she wanted to double check with medical records. On 5/30/25 at 8:31 A.M., another interview was conducted with the AD. The AD stated there was no documentation of an advanced directive being offered, accepted, or declined by Resident 56. A review of the admission Agreement titled California Standard admission Agreement For Skilled Nursing Facilities and Intermediate Care Facilities which Resident 56 signed on 8/14/23, indicated .If you do not know how to prepare an Advance Health Care Directive and wish to prepare one, we will help you find someone to assist you in doing so On 5/30/25 9:30 A.M., an observation and interview was conducted with Resident 56. Resident 56's right eye was mostly closed with only part of the sclera (white part of the eye) visible. Resident 56 stated he could not see during the time of admission, I was blind. Resident 56 stated he had surgery on his right eye and could now see somewhat better. Resident 56 stated during the admission process the admission agreement was read to him and it was about five minutes, it was quick. Resident 56 stated there was no way all 31 pages of the admission agreement was read to him in five minutes. Resident 56 stated he would have liked to have been offered assistance with creating an advanced directive. A review of the facility's policy and procedure titled ADVANCED DIRECTIVES revised 2013 indicated, .the facility staff will offer assistance in establishing advance directives. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of 24 residents (33, 56, 76, 27) had a safe and homelike environment when the facility did not: 1. Replace or reimburse lost belongings for Resident 33. 2. Provide a living environment that was clean and well maintained for Residents 56, 76 and 27. As a result, Resident 33 did not have the ability to have a different shirt for each day of the week. In addition, there was the potential for Residents 56, 76 and 27 to feel uncomfortable in their environment. Findings: 1. On 5/27/25 at 3:07 P.M., during initial screening, Resident 33 was interviewed. Resident 33 stated he was missing cloths, specifically the facility could not find 3 of his shirts. Resident 33 stated he notified the facility, but they had not replaced or reimbursed, the lost shirts. Resident 33 stated he was told they were waiting for corporate's decision on replacing or reimbursing the shirts. On 5/28/25 at 9:30 A.M., the Social Services Director (SSD) was interviewed. The SSD stated the decision was made to not replace or reimburse the 3 missing shirts because they were not on the belongings sheet. Resident 33's clinical record was reviewed on 5/28/25. The belongings sheet dated 1/5/24 was reviewed. According to the belonging sheet on 7/27/24, Resident 33 had, 8 pcs [pieces] shirts. On 1/15/25 Resident 33 reported to the SSD he was missing two of his shirts. The SSD made an effort to find the shirts by looking in the resident's closet, dresser, laundry, the linen closet and on the floor. The missing shirts were not found. On 5/28/25 at 10:20 A.M., the Administrator was interviewed. The Administrator stated the shirts should have been replaced. 2. Resident 56 was admitted to facility on 8/12/23 per the resident's admission Record. Resident 76 was admitting on 11/8/24 per resident's admission Record. Resident 27 was admitted to the facility on [DATE] per the resident's admission Record. On 5/27/25 at 8:50 A.M., an interview and observation was conducted with Resident 56 while inside of the resident's room. Resident 56 stated he would like to complain about the bathroom. Resident 56 stated the bathroom toilet would leak. The resident's bathroom was observed and there was no caulking around the bottom of the toilet. There was a missing baseboard behind the toilet and there were cobwebs in the vent on the ceiling. Resident 56 stated if it was his house he would have had it fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at 9:00 A.M., an interview conducted with the roommate of Resident 56. Resident 56's roommate stated he would like to have the bathroom fixed. On 5/27/25 at 11:00 A.M., an interview and observation was conducted with Resident 27 while inside the resident's room. Resident 27 stated there has been a hole in the wall since his admission on [DATE]. Resident 27 stated he would not leave a hole in his wall at home and would go to [hardware store] for supplies and fix it. The wall behind the resident's door was observed to have a hole approximately three by two inches. On 5/29/25 at 1:30 P.M., an interview and observation was conducted with Certified Nurse Assistant (CNA) 31. CNA 31 observed Resident 56's bathroom. CNA 31 observed the missing caulking around the toilet, missing baseboard behind the toilet, and cobwebs in the ceiling vent. CNA 31 stated the bathroom was not a home-like environment. CNA 31 stated the condition of Resident 56's bathroom should have been reported in the maintenance log. CNA 31 stated it looks unkept and I will report it to maintenance. On 5/29/25 at 1:36 P.M., an interview and record review was conducted with Licensed Nurse (LN) 32. LN 32 stated maintenance needs should be written in the maintenance binder that is kept in Station A for whole facility. The maintenance binder was reviewed. There was no documentation of an issue in Resident 56's bathroom nor was there documentation of the hole in Resident 27's wall. On 5/29/25 at 1:43 P.M., an interview and observation was conducted with the Maintenance Supervisor (MS). The MS observed Resident 56's bathroom. The MS stated the toilet needed caulking and the baseboard needed to be replaced. The MS stated he was responsible for cleaning the vents on the ceiling but that he did not have time to do it. The MS stated, I don't have time to fix it because I'm by myself. The MS stated he did not do room checks. On 5/29/25 at 1:55 P.M., an interview and observation was conducted with the MS. The MS observed the hole in the wall behind Resident 27's door. The MS stated this was not a homelike environment. On 5/30/25 at 3:25 P.M., an interview was conducted with the Director on Nursing (DON). The DON stated the facility should be visually appealing and foster a homelike environment. The DON stated Resident 56's bathroom and the hole in Resident 27's wall should have been fixed. A review of the facility policy titled Homelike Environment revised February 2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment . a. Clean, sanitary and orderly environment, c. inviting colors and décor

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review, a Minimum Data Set (MDS- a federally mandated resident assessment tool) to determine the Significant Change of Status Assessment (SCSA-an improvement or decline), and/or update a care plan for one of five residents sampled (Resident 9) according to the Resident Assessment Instrument (RAI-MDS manual). This deficient practice placed Resident 9 for delayed care planning and unmet care needs. Cross-Reference F640 and F657 Findings: A review of Resident 9's admission Record indicated Resident 9 was re-admitted to the facility on [DATE] with diagnoses which included a history of pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred making it hard to breath). A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page 2-25) .After the IDT (Interdisclipnary Team) has determined that a resident meets the significant change in the resident's status in the clinical record . A clinical chart review for Resident 9 was conducted. Resident 9's IDT Skilled Review Note dated 4/24/25, indicated that, .Transfer: Pt. [patient] is dependent sit to stand-not attempted .personal hygiene and maximal assistance x2 [two-person assistance] .Pt still being monitor [sic] with her respiratory treatment and weight loss, pt continues to progress in rehab services and has not met her/his goal . A clinical chart review of Resident 9's activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care plan revised date 1/25/25 did not include SCSA updated information of Resident 9's improvement. On 5/28/25 at 8:16 A.M., an interview was conducted with the MDS nurse (MDSN). The MDSN stated Resident 9 had a SCSA assessment reference date (ARD) on 4/30/25. The MDSN stated that Resident 9 had improved with ADLs for eating, oral hygiene, and toileting. The MDSN stated Resident 9's care plan was not revised with the ADL improvement per SCSA look-back (from determination date to ARD within 14 days of determination to complete). The MDSN stated that the IDT determines when an SCSA MDS would need to open. The MDSN stated Resident 9's SCSA ARD was opened on 4/30/25. The MDSN stated that Resident 9's IDT Comprehensive Skilled Review dated 4/24/25 did not indicate that an SCSA was discussed with the IDT regarding Resident 9's improvement with ADLs. The MDSN stated Resident 9's physician (MD) was not notified regarding Resident 9's IDT Comprehensive Skilled Review dated 4/24/25 for improvement. The MDSN stated that the Comprehensive Skilled Review did not determine if an SCSA was appropriate and did not determine a SCSA date. The MDSN stated that the IDT would need to solidify if an SCSA was indicated during the Comprehensive Skilled Review but did not. The MDSN further stated that the SCSA MDS and care plan was also not completed on time. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 3:03 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was for the MDSN and IDT know the criteria of an SCSA based on the RAI manual and to discuss improvements or decline for residents (all facility residents) if there was indeed a significant change in status. The DON stated this was important to promote the overall physical, mental and psychosocial well-being of Resident 9 to prevent declining back to increased assistance. A review of the facility's policy and procedure titled CHANGE in a RESIDENT's CONDITION or STATUS, revised 2015 indicated, .Requires interdisciplinary review and/or revision to the care plan .Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS - a federally mandated resident assessment tool) and Care Area Assessment (CAA) on time, as required by the Resident Assessment Instrument (RAI-MDS manual), for one of five sampled residents (Resident 9). This deficient practice placed Resident 9 at risk for delays in care planning and unmet care needs. Cross-Reference F637 and F657 Findings: A review of Resident 9's admission Record indicated Resident 9 was re-admitted to the facility on [DATE] with diagnoses which included a history of pulmonary fibrosis (is a lung disease that occurs when lung tissue becomes damaged and scarred making it hard to breath). A record review of Resident 9's MDS dated [DATE] Section Z indicated, a signature completion dated 5/15/25. The transmission report indicated: .Assessment Completion Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date [ARD]) . .Care Plan Completed Late: V0200B2 (CAA process signature date) is more than 14 days after 2300 (assessment reference date) . On 5/30/25 at 9:26 A.M., an interview was conducted with the MDS nurse (MDSN). The MDSN stated that Resident 9's required assessments (MDS and CAA) had not been completed on time. The MDSN stated that Resident 9's MDS should be signed and completed within 14 days of Resident 9's ARD. The MDSN stated that Resident 9's MDS needed to be completed and sent to the federal database on time and care plan updated to meet their needs. The MDSN stated Resident 9 had a comprehensive Significant Change of Status Assessment (SCSA- an MDS comprehensive assessment for a decline or improvement), but the care plan was not updated that reflected Resident 9's improvements. The MDS nurse stated a late MDS completion could have delayed needed care updates and may have caused Resident 9 to not receive care that promoted their improved levels with self-care on activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) to prevent a decline in Resident 9's independence or needing more assistance again. On 5/30/25 at 3:03 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important that the MDS and CAA be completed within 14 days to reflect a resident's (all facility residents) current condition. The DON stated that her expectations were for the MDSN to be updating the care plans as triggered with the CAA and completed on time. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page 2-21) .OBRA [Omnibus Budget Reconciliation Act- a series of federal laws enacted by Congress] required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning .The MDS completion date (item Z0500B) must be no later than 14 days from the ARD .The CAA(s) completion date (item V9299B2) must be no later than 14 days .14 days from the ARD .The CAA(s) completion date (item V9299B2) must be no later than 14 days .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a person-centered care plan that included activities based on resident's preferences for one of five sampled residents (Resident 9). This deficient practice placed Resident 9 at risk for not having their individual needs and interests supported, which could negatively affect their emotional well-being and quality of life. Cross-Reference F679 Findings: A review of Resident 9's admission Record indicated Resident 9 was re-admitted to the facility on [DATE] with diagnoses which included a history of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident 9's minimum data set (MDS-a federally mandated resident assessment tool) dated 4/30/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 9 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 5/27/25 at 2:51 P.M., an interview was conducted with Resident 9, in Resident 9's room. Resident 9 stated she can get out of bed and on her wheelchair with assistance and is unable to walk. Resident 9 stated she liked doing social activities such as bingo, and doing social coffee with the rest of the residents in the facility. Resident 9 was wearing a facility gown while in bed and stated she did not get her outfit changed that day and would have rather worn her own clothing if she was assisted to get out of bed. On 5/29/25 at 8:47 A.M., an interview was conducted with Resident 9, in Resident 9's room. Resident 9 stated she was unsure if she would be joining activities today because she needed assistance to get out of bed. On 5/30/25 at 11:15 A.M., an interview and record review was conducted with the Activities Director (AD). The AD stated I know I should be more encouraging for the resident [Resident 9] and will try to make activities more social for Resident 9. On 5/30/25 at 2:16 P.M., an interview and record review was conducted with the AD. The AD stated that Resident 9's care plan interventions was not updated since 6/17/24 that did not include Resident 9's preferred activities to be conducted per Resident 9's ACTIVITIES PARTICIPATION REVIEW for 3-5x week. The AD stated she was not aware she needed to update activity care plans when re-assessments were conducted with quarterly and comprehensive evaluations. The AD stated It's important because it's important [sic] mentally, physically, and well being of resident's overall health to promote happiness, quality of life and prevents decline. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 3:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated activities should be established through resident (facility residents) interviews and needed to be tailored (personalized) to what activities a resident preferred (e.g. wants bingo one times per week versus 3x per wk). The DON stated this was important to take Resident 9's preferred activity participation that promotes their quality of life with activities that promote socialization and prevent mental decline. The DON further stated the AD should update and contribute as part of the interdisciplinary team (IDT) to revise the activity preferences of a resident's (facility residents) plan of care. A review of the facility's policy and procedure titled CARE PLANS, COMPREHENSIVE PERSON-CENTERED revised March 2022, indicated, .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. Participate in the planning process; .f. participate in determining the type, amount, frequency and duration of care; .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the care plan after a Significant Change of Status Assessment (SCSA), as required by the federal guidelines, for one of five sampled residents (Resident 9). This deficient practice placed Resident 9 at risk for receiving care that did not reflect their current condition, which could delay needed support, and negatively affecting their health and well-being. Cross-Reference F637 and F640 Findings: A review of Resident 9's admission Record indicated Resident 9 was re-admitted to the facility on [DATE] with diagnoses which included a history of pulmonary fibrosis (is a lung disease that occurs when lung tissue becomes damaged and scarred making it hard to breath). A clinical chart review of Resident 9's activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care plan revised date 1/25/25 did not include SCSA updated information of Resident 9's improvement. On 5/30/25 at 9:26 A.M., an interview was conducted with the MDS nurse (MDSN). The MDSN stated that Resident 9's required assessments (MDS and CAA) had not been completed on time. The MDSN stated Resident 9 had a comprehensive Significant Change of Status Assessment (SCSA- an MDS comprehensive assessment for a decline or improvement), but the care plan was not updated that reflected Resident 9's improvements. The MDSN stated a late MDS completion could have delayed needed care updates and may have caused Resident 9 to not receive care that promoted their improved levels with self-care on ADL to prevent a decline in Resident 9's independence or needing more assistance again. On 5/30/25 at 3:03 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important that the MDS and CAA be completed within 14 days to reflect a resident's (all facility residents) current condition. The DON stated that her expectations were for the MDSN to be updating the care plans as triggered with the CAA and completed on time. A review of the facility's policy and procedure titled CARE PLANS, COMPREHENSIVE PERSON-CENTERED revised 2022 indicated, .The interdisciplinary team reviews and updates the care plan: a.When there has been a significant change in the resident's condition .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of six residents, who were unable to carry out activities of daily living (ADL-self- care activities such as grooming, bathing, and toileting), received assistance with nail care (cleaning, trimming and/or filing of nails) and shaving (Resident 5, 26 and 39). This failure resulted in residents having long and dirty fingernails which had the potential to negatively impact the residents' self-esteem and comfort. Findings: Resident 5 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain) according to the facility's admission Record. A review of Resident 5's care plan initiated on 2/2/23 indicated, Resident .requires assistance related to impaired mobility .Will provide assistance with ADLs as indicated. During an observation and interview on 5/27/25 at 8:55 A.M. with Resident 5, Resident 5 was observed with long fingernails and with debris underneath the nails. Resident 5 stated she would like her fingernails trimmed. A joint observation and interview on 5/28/25 at 8:53 A.M. was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 completed changing Resident 5's brief and checked Resident 5's fingernails. CNA 3 stated Resident 5 needed nail care. CNA 3 stated nail care was scheduled every Sundays. CNA 3 further stated having long fingernails could cause fungus and bacteria in the nails. Resident 26 was admitted to the facility on [DATE] with diagnoses including muscle weakness and lymphedema (buildup of fluid under the skin) according to the facility's admission Record. A review of Resident 26's Minimum Data Set (MDS- a clinical assessment tool) dated 3/4/25 indicated dependent assistance for personal hygiene. During an observation and interview on 5/27/25 at 9:20 A.M., Resident 26 was in bed and stated he was aware of his long fingernails, but he preferred to trim them himself. Resident 26's fingernails had black debris under the fingernails, and Resident 26 stated he would like staff to clean under his fingernails. During a joint observation and interview on 5/28/25 at 10:32 A.M. with Licensed Nurse (LN)3, LN 3 stated Resident 26's fingernails needed to be cleaned for good hygiene. Resident 39 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (brain conditions that causes slowed movements, rigidity and tremors) according to the facility's admission Record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 39's MDS dated [DATE] indicated Resident 39 required Substantial/maximal assistance with personal hygiene. During an observation and interview on 5/27/25 at 3:02 P.M., Resident 39 was in bed and responded by mumbling. Resident 39 showed his hands with long fingernails and black debris under the nails. A concurrent observation and interview was conducted with the treatment (Tx) nurse on 5/28/25 at 9:43 A.M. Resident 39 was in a wheelchair in front of the nurse's station. The Tx nurse checked Resident 39's hands and stated Resident 39's fingernails needed to be trimmed and cleaned for infection control. An interview on 5/30/25 at 10:39 A.M. was conducted with the Director of Nursing (DON). The DON stated residents' fingernails should be short and trimmed to prevent skin tears. The DON further stated fingernails should be cleaned for infection control. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, dated February 2018, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide meaningful activities that matched the preferences and needs of one of five sampled residents (Resident 9) based on their comprehensive, resident-centered care plan and assessment. This deficient practice placed Resident 9 at risk for decreased mental and emotional well-being, social isolation, and reduced quality of life. Cross-References F656 Findings: A review of Resident 9's admission Record indicated Resident 9 was re-admitted to the facility on [DATE] with diagnoses which included a history of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident 9's minimum data set (MDS-a federally mandated resident assessment tool) dated 4/30/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 9 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 5/27/25 at 2:51 P.M., an interview was conducted with Resident 9, in Resident 9's room. Resident 9 stated she can get out of bed and on her wheelchair with assistance and is unable to walk. Resident 9 stated she liked doing social activities such as bingo, and doing social coffee with the rest of the residents in the facility. Resident 9 was wearing a facility gown while in bed and stated she did not get her outfit changed that day and would have rather worn her own clothing if she was assisted to get out of bed. On 5/29/25 at 8:47 A.M., an interview was conducted with Resident 9, in Resident 9's room. Resident 9 stated she was unsure if she would be joining activities today because she was unsure she would get assistance to get out of bed. On 5/30/25 at 11:15 A.M., an interview and record review was conducted with the Activities Director (AD). The AD stated Resident 9 does not see very well and visits Resident 9 to read to her. The AD stated she did, Check-ins with Resident 9 and stated Resident 9 would talk to you. The AD stated Resident 9 liked to color and was the main thing she liked to do. The AD stated Resident 9 also liked hand lotion massage for 1:1 activities. The AD stated she did activity evaluations/assessments on a quarterly and annual basis. The AD stated it was difficult to make rounds with all residents in the facility because she only had a part-time. The AD stated, I know I should be more encouraging for the resident (Resident 9) and will try to make activities more social for Resident 9. On 5/30/25 at 2:16 P.M., an interview and record review was conducted with the AD. The AD reviewed Resident 9's activity participation on Resident 9's clinical chart with activities on: - March 2025: 3/3/25, 3/17/25, 3/18/25 and 3/25/25 (social/group activities). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- April 2025: 4/2/25, 4/20/25 (social/group activities), 4/22/25 (social/group activities), 4/25/25 (social/group activities), 4/26/25 (social/group activities) and 4/28/25 (social/group activities). - May 2025: 5/2/25, 5/3/25 (social/group activities), 5/4/25 (social/group activities), 5/10/25 (social/group activities), 5/11/25 (social/group activities), 5/13/25, 5/16/25, 5/17/25 (social/group activities), 5/18/25 (social/group activities), 5/19/25-5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/28/25 and 5/29/25. The AD stated Resident 9's ACTIVITIES PARTICIPATION REVIEW on 1/30/25 and 4/30/25 indicated, . Resident engages in independent activities of choice 3-5x/wk [three to five times per week] .Resident enjoys activities such as music, watching, TV, conversation, starters, staff, visits, refreshments, coloring pages and hand lotion massage . The AD stated Resident 9 did not receive activities as preferred 3-5x/wk in March 2025 and April 2025. The AD stated the social activities indicated, were offered to Resident 9 but limited from April through May. The AD stated during the month of March and April activities was not provided to Resident 9 according to Resident 9's preferences. The AD also stated that Resident 9's care plan was initiated 5/15/25 with the goal that stated .Resident will have daily stimulation/interactions . with interventions not updated since 6/17/24. The AD stated she was not aware she needed to update activity care plans when re-assessments were conducted with quarterly and comprehensive evaluations. The AD stated, It's important because it's important [sic] mentally, physically, and well being of resident's overall health to promote happiness, quality of life and prevents decline. On 5/30/25 at 3:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated activities should be established through resident interviews and needed to be tailored (personalized) to what activities a resident preferred. The DON stated this was important to take Resident 9's preferred activity participation that promotes their quality of life with activities that promote socialization and prevent mental decline. The DON further stated the AD should update and contribute as part of the interdisciplinary team (IDT) to revise the activity preferences of a resident's (facility residents) plan of care. A review of the facility's policy and procedure titled ACTIVITY PROGRAMS revised June 2018, indicated, . Activities offered are based on the comprehensive resident centered assessment and the preferences of each resident .

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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 ensure one of four residents reviewed for accidents was free of accidents during the use of a Hoyer lift (mechanical lift device used to move immobile residents). (Resident 26) This failure resulted in the Hoyer lift hitting Resident 26's left knee which caused Resident 26 pain. Findings: Resident 26 was admitted to the facility on [DATE] with diagnoses including muscle weakness and chronic venous hypertension (persistent high blood pressure in the veins, typically in the legs) with inflammation (redness and swelling) of left lower extremity according to the facility's admission Record. During an interview on 5/27/25 at 9:20 A.M. with Resident 26, Resident 26 stated a Certified Nurse Assistant (CNA) weighed him on 5/26/25. Resident 26 stated the CNA caused him pain because the sling (supports the body which connects to the lift) was not applied correctly and the metal part of the lift hit his left knee. Resident 26 stated he had arthritis (joint swelling and tenderness) on his left knee. During a review of Resident 26's Minimum Data Set (MDS- a clinical assessment tool) dated 3/5/25, the MDS functional abilities section GG0170A indicated Resident 26 required dependent assistance for rolling left and right on the bed. The MDS further indicated in section GG0170C lying to sitting on the side of the bed was Not attempted due to medical condition or safety concerns. During an interview on 5/28/25 at 11:46 A.M. with the Restorative Nurse Assistant (RNA) 1, RNA 1 stated he and another RNA weighed residents on Mondays. RNA 1 stated if a Hoyer lift was used to weigh a resident, a two-person assist was needed for safety. An interview on 5/28/25 at 11:50 A.M. was conducted with RNA 2. RNA 2 stated she weighed Resident 26 on 5/26/25 using the Hoyer lift. RNA 2 stated she was alone because the other CNAs were on a break. RNA 2 stated she was taught to always have two people when using the Hoyer lift for safety reasons. During an interview on 5/28/25 at 12 P.M. with the Director of Staff Development (DSD- a licensed nurse certified for staff training), the DSD stated she expected staff to have two people upon using a Hoyer lift for weighing residents. The DSD stated the CNA assigned to the resident should assist the RNA for safety and in case the machine malfunctioned. During an interview on 5/30/25 at 10:39 A.M. with the Director of Nursing (DON), the DON stated there should be a two person assist when staff used the Hoyer lift for resident and employee safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Lifting Machine, Using a Mechanical, dated July 2017 was conducted. The P&P indicated, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device .At least two [2] nursing assistants are needed to safely move a resident with a mechanical lift.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 40) with Post Traumatic Stress Disorder (PTSD) out of 24 sampled residents received trauma-informed care. This failure had the potential to re-trigger trauma for Resident 40. Findings: Review of admission Record for Resident 40 indicated she was admitted on [DATE] for diagnoses which included fractured left Radial Styloid Process (a bony projection located on the lower end of the forearm) , Seizures (a sudden, temporary disturbance in brain activity that causes changes in behavior, movement, sensation, or consciousness), Repeated Falls, Traumatic Brain Injury (a disruption of the normal function or structure of the brain caused by an external force), and Post Traumatic Stress Disorder (a mental health condition that's caused by an extremely stressful or terrifying event). Review of MDS Section C-Cognitive (thinking processes) Patterns indicated a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. Review of Care Plan Report-Psychosocial (the interrelation of social factors and individual thought and behavior) Emotional Trauma indicated At risk for decrease psychosocial well-being .related to Post Traumatic Stress Disorder (PTSD) triggered by incidents when she feels belittled/put down due to history of abusive relationships. Resident is also triggered by driving due to history of car accidents . On 5/30/25 at 8:35 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 41 who took care of Resident 40 that morning. CNA 41 stated she was not aware Resident 40 had a PTSD diagnosis. CNA 41 further stated she did not know Resident 40's triggers for her specific PTSD. CNA 41 stated that she did not remember if she was trained about PTSD. CNA 41 stated that if she knew the triggers she could help resident avoid the triggers. On 5/30/25 at 8:45 A.M., an interview was conducted with Registered Nurse (RN) 42. RN 42 was Resident 40's medication nurse for the day. RN 42 stated that she was aware of Resident 40's PTSD diagnosis, but did not know specifically what her PTSD was from or her triggers. RN 42 stated that the expectation was that staff should know about their resident's PTSD and what their triggers were. RN 42 stated the importance of knowing triggers was to avoid them. On 5/30/25 at 9:02 A.M., an interview was conducted with Social Service Director (SSD). The SSD stated that she was aware of Resident 40's PTSD and had interviewed her about her triggers. The SSD stated that Resident 40 did not like car rides as she had been in many car accidents. In addition, Resident 40 did not like to see others abused, as she had been in an abusive relationship. The SSD stated that there is a PTSD binder on the unit with everyone's PTSD Care Plan which included their triggers. The SSD stated that the expectation was that clinical staff taking care of residents with PTSD should be aware of resident's PTSD and their triggers. The SSD stated the importance of knowing triggers of PTSD, was to avoid bringing up past traumas. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 9:30 A.M., an interview was conducted with Charge Nurse (CN) 43. CN 43 was not aware of where to find Resident 40's PTSD or triggers. CN 43 stated that she was not aware of the PTSD book on the unit. CN 43 stated that the expectation was that clinical staff taking care of PTSD residents should be aware of what resident's PTSD was and their triggers to prevent emotional distress for residents with PTSD. On 5/30/25 at 10 A.M., an interview with the Director of Staff Development (DSD) and record review of the facility document Inservices 2025 was conducted. The DSD stated that there were no planned In-services for PTSD scheduled for 2025 per the calendar. The DSD stated that the expectation for clinical staff was that if their resident had PTSD, they should review the PTSD binder located at the nursing station to be familiar with their resident's PTSD care plan and to understand their PTSD and their triggers. The DSD stated the importance of knowing their PTSD and their triggers was to know how to approach the resident, avoid triggers, and help to de-escalate the resident if triggered. On 5/30/25 at 11 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated the expectation for PTSD residents was that the staff should know what the resident's PTSD is from and what triggers the resident. The DON stated that the staff should care plan the PTSD and put that care plan in the PTSD book available at the nursing station. The DON stated that there should be scheduled in-services for PTSD by the DSD. The DON stated that clinical staff should be aware of the PTSD book at the nursing station. The DON stated the importance of clinical staff awareness of resident's PTSD and triggers was to prevent triggering traumatic experiences unnecessarily in residents causing them further emotional trauma. Review of facility policy titled Trauma Informed Care and Culturally Competent Care dated 2001, indicated . To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .Resident Assessment .1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as identification of triggers .Resident Care Planning .2. Identify and decrease exposure to triggers that may retraumatize the resident .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to ensure employee performance evaluations were completed annually for two of five Certified Nurse Assistants (CNA) reviewed for performance reviews. This deficient practice had the potential for CNAs to provide inadequate care to the residents. Findings: A concurrent record review and interview was conducted with the Director of Staff Development on 5/30/25 at 8:02 A.M. The DSD checked five CNA files for performance evaluations which indicated the following: CNA 8 was hired by the facility on 4/27/23 and there were no performance evaluations completed for 2024 and 2025. CNA 9 was hired by the facility on 1/25/22 and there were no performance evaluations completed for 2023 and 2025. The DSD stated it was important for employees to have evaluations to know the needs of the employees to better care for the residents. During an interview with the Director of Nursing (DON) on 5/30/25 at 10:39 A.M., the DON stated employee evaluations should be completed annually to evaluate the employee's attendance, skills, goals and the need for training. A review of the facility's policy and procedure (P&P) titled, Performance Evaluations, dated September 2020 was conducted. The P&P indicated, A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter .Performance evaluations may be used in determining employee promotions, shift/position transfers, demotions, terminations, wage increases, etc., and to improve the quality of the employee's work performance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered according to professional standards of practice for one of 24 sampled residents (41) and four unsampled residents (63,80, 191, 36) reviewed for pharmacy services when: 1. Resident 63's Aspirin 81 mg chewable (a prescribed medication as a stroke prophylaxis) was administered over the one hour allotted time frame. 2. The manufacturer's instructions for Fluticasone nasal spray (a nasal spray for allergies) was not followed when the medication was administered to Resident 191. 3. Resident 41's G-tube (a surgical opening fitted with a device to allow feedings or medications to be administered directly to the stomach) was not properly auscultated for placement before medication administration. In addition, the Licensed Nurse (LN 35) did not administer the resident's medication by gravity. 4. Controlled medications (drugs with high abuse potential) prescribed to Resident 80 and Resident 36 could not be accounted for. As a result, the facility could not ensure pharmaceutical services were safely provided to its residents. In addition, the facility was unable to readily identify potential loss and/or drug diversion (illegal distribution or abuse of prescription drugs). Findings: 1. A review of Resident 63's admission Record indicated the resident was admitted to the facility on [DATE]. On 5/29/25 9:15 A.M., a medication administration observation was conducted with Licensed nurse (LN) 33. LN 33 was observed preparing, dispensing, and then administering the aspirin to Resident 63. A review of Resident 63's physician orders dated 3/19/25, indicated the resident was to receive aspirin 81 milligrams once a day. The medication was scheduled to be administered at 7:00 A.M. A review of Resident 63's medication administration record (MAR) indicated the resident's aspirin was documented as administered to the resident on 5/29/25 at 9:39 A.M. On 5/30/25 at 8:56 A.M., an interview and record review was conducted with LN 32. LN 32 reviewed Resident 63's MAR dated 5/29/25 and stated administration for Aspirin order time is 7:00 A.M. daily. LN 32 stated Resident 63's aspirin administration occurred at 9:39 A.M. LN 32 stated, it was late. LN 32 stated it was important to follow physician's order. On 5/30/25 at 3:25 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 63's aspirin was not administered timely. The DON stated it was her expectation for all nursing staff to follow the physician's orders. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Administering Medications, revised 4/2019, indicated, .4. Medications are administered in accordance with prescriber orders, including any required timeframe 2. A review of Resident 191's admission Record indicated the resident was admitted on [DATE]. On 5/29/25 at 10:05 A.M., a medication administration observation was conducted with licensed nurse (LN) 34. LN 34 was observed preparing and dispensing medications for Resident 191. LN 34 was observed administering Fluticasone nasal spray to Resident 191. LN 34 instructed Resident 191 to tilt her head back as LN 34 assisted with administering nasal spray in Resident 191's nostrils. A review of the Fluticasone packaging insert indicated, .Instructions for using Fluticasone nasal spray .Step 2. Close one nostril. Tilt your head forward slightly and keeping the bottle upright .Step 7. Wipe the nasal applicator with a clean tissue and replace the translucent cap On 5/30/25 at 8:56 A.M., an interview was conducted with LN 32. LN 32 stated it was important to follow manufacturer guidelines for the medication to be effective. On 5/30/25 at 9:12 A.M., an interview and record review was conducted with LN 34. LN 34 reviewed the Fluticasone nasal spray packaging insert (for Resident 191's Fluticasone). LN 34 stated she did not follow the manufactures instructions when administrating the Fluticasone nasal spray to Resident 191. LN 34 stated she should have instructed the resident to tilt her head forward. LN 34 stated it was important to follow manufacture guidelines for the medication to be effective. On 5/30/25 at 3:25 P.M., an interview was conducted with the DON. The DON stated her expectation was for all nursing staff to follow manufactures guidelines when administering medications for the medication to be effective. The DON stated LN 34 should have instructed Resident 191 to tilt her head forward. 3. A review of Resident 41's admission Record indicated the resident was admitted on [DATE]. On 5/29/25 at 8:15 A.M., a medication administration observation was conducted with licensed nurse (LN) 35. LN 35 was observed preparing a medication to be administered via G-tube for Resident 41. LN 35 was observed auscultating Resident 41's G-tube with 10 cc of water to check for placement before administering medication. LN 35 stated Its good. LN 35 was observed using the syringe/plunger to push the medication and a water flush into the resident's G-tube. LN 35 did not attempt to administer the medication or water flush via gravity. On 5/30/25 at 8:56 A.M., an interview was conducted with LN 32. LN 32 stated to verify placement of a G-tube before medication administration, the LN had to push a syringe filled with air into the G-tube while auscultating the resident's abdomen. LN 32 stated medication administered via G-tube had to be given via gravity. On 5/30/25 at 9:23 A.M., an interview was conducted with LN 35. LN 35's observed medication administration for Resident 41 on 5/29/25 was discussed. LN 35 acknowledged she had auscultated the water flush to verify placement and did not attempt to administer the resident's medication via gravity. LN 35 stated, That is my practice. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/25 at 3:25 P.M., an interview was conducted with the DON. The DON stated it was important to know the placement of a G-tube to ensure medication or feeding is going into the stomach and not the lungs. The DON stated placement was verified by auscultating air injected into the G-tube and listening with a stethoscope for placement. The DON stated medication and water flush should be administered by gravity as per policy. The DON stated her expectation was for all nursing staff to follow facility policy. Per facility policy and procedure titled Administering Medication through and Enteral Tube, revised November 2018, indicated, .6. Verify placement of feeding tube 12. Administer medication by gravity flow: A. pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. B. Open the clamp and deliver medication slowly 4a. A review of Resident 80's admission Record indicated the resident was admitted on [DATE]. Resident 80's physician's order, controlled drug record (CDR), and electronic medication administration record (EMAR) was reviewed. Resident 80's physician's order dated 3/23/25, indicated the resident was to receive oxycodone 2.5 mg (medication used to relieve pain) one tab every four hours as needed for pain level of 4-6 (self-rated pain score indicating moderate pain) and oxycodone 5 mg one tab every six hours as needed for pain level of 7-10 (self-rated pain score indicating severe pain). A review of Resident 80's EMAR indicated on 5/13/25 and 5/15/25, the resident's oxycodone 5 mg was signed out on the CDR but was not documented on the EMAR. Resident 80's oxycodone 5 mg had been removed again from the locked supply on 5/13/25 and 5/24/25. Resident 80's EMAR for oxycodone 5 mg had blank entries on 5/13/25 and 5/24/25 and it could not be determined if the medication had been given to the resident. 4b. A review of Resident 36's admission Record indicated the resident was admitted on [DATE]. A review of Resident 36's physician's order, CDR, and EMAR was conducted. Resident 36's order dated 4/19/25, indicated the resident was to receive Norco oral tab 10-325 mg (medication used to relieve pain) one tab every four hours as needed for moderate to severe pain. A review of Resident 36's CDR indicated the resident's Norco10/325mg was removed from locked storage on 5/27/25 and 5/28/25 but was not documented on the EMAR. It could not be determined if the medication had been given to the resident. On 5/30/25 at 1:58 P.M., an interview and record review was conducted with LN 35. LN 35 stated she had to sign controlled medications out on the CDR and document on the EMAR when the medication was given to the resident. LN 35 stated that it was important to keep track of controlled medications so that other LNs knew when the medication was given. LN 35 reviewed Resident 36's CDR and EMAR for Norco 10/325 on 5/27/25 and 5/28/25. LN 35 stated she should have documented when she administered the medication in the resident's EMAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/25 at 2:12 P.M., an interview with record review was conducted with the Assistant Director of Nursing (ADON). The ADON reviewed Resident 80's CDR and EMAR for oxycodone 5 mg on 5/13/25 and 5/24/25. The ADON stated the administration of the resident's oxycodone was not documented on the EMAR. The ADON reviewed Resident 36's CDR and EMAR for Norco 10/325mg on 5/27/25 and 5/28/25. The ADON stated the resident's Norco administration was not documented on EMAR. The ADON stated when a controlled medication was given to a resident, nurses were required to document the medication administration right away. The ADON stated she did not audit the CDR or EMAR. On 5/30/25 at 3:25 P.M., an interview was conducted with the DON. The DON stated the importance of reconciling controlled medications was to ensure accurate accounting of controlled drug medication and to prevent drug diversion. The DON stated her expectation was for the EMAR and CDR to match. The facility's policy and procedure, titled Controlled Substance, revised November 2022, indicated, . Dispensing and reconciling controlled substances 1. Controlled substances inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimized the time between loss/diversion and detection/follow-up

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, the facility failed to ensure medications were stored and labeled according to acceptable standard of practice during an inspection of two of three medication carts, and one of two medication rooms when: 1. Expired insulin (medication to lower blood sugar levels) was stored in a medication cart. 2. Ipratropium/albuterol inhalation (breathing medication) was stored unprotected from light in the medication cart. 3. A box of Ampicillin 3 grams vials was stored inside a drawer in the medication room without the medication label. These failures had the potential for medications to have reduced effectiveness and/or medication misuse. Findings: On [DATE] at 2:34 P.M., an observation and interview was conducted with Licensed Nurse (LN) 35. LN 35's assigned medication cart was inspected. Ipratropium/albuterol inhalation vials were kept in a foil packing in a box that had the lid open. The medication was exposed to light when the medication cart was opened. LN 35 stated the lid should have been closed to protect the medication from light. A review of patient information for Ipratropium/albuterol inhalation from (manufacture name) dated [DATE], indicated, .Protect from light. Keep unused vials in the foil pouch or carton On [DATE] at 2:35 P.M., an observation and interview was conducted with LN 33. LN 33's medication cart was inspected. A vial of Humalog 100 units (insulin) had an opened date of [DATE]. LN 33 stated it should have been discarded because it may lose it potency after 28 days. On [DATE] at 2:45 P.M., an observation and interview was conducted with LN 36 while inside the medication room. An unlabeled box of Ampicillin 3 gram vials (8 vials) was kept inside a drawer. The drawer also contained a plastic bag and a pen. LN 36 stated she did not know why the medication was kept in the drawer with no label. On [DATE] at 2:12 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the box of Ampicillin should have been in a plastic bag with a label of the resident's name and other information on it from the pharmacy. The ADON stated the medication should have been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:25 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated expired insulin could lose its potency. The DON stated her expectation was for all nurses to take expired medication out of cart and discard them. The DON stated the box of Ipratropium/albuterol inhalation should have been closed at all times to protect the medication from the light. The DON stated the Ampicillin should have been discarded. A review of facility's policy titled Medication Labeling and Storage, revised February 2023, indicated, . Medication Labeling . 2. The medication label includes at a minimum; a. medication name prescribed dose . e. Resident's name . 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days According to the FDA's online document titled Information Regarding Insulin Storage and Switching Between Products in an Emergency dated [DATE], indicated, .insulin products in vials or cartridges supply by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 [degrees Fahrenheit] and 86 [degrees Fahrenheit] for up to 28 days and continue to work

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and interview the facility failed to ensure the meal tray diets were verified by a licensed nurse prior to distributing to residents. As a result, the residents may have been given a diet that was incorrect. Findings: On 5/28/25 the lunch trays were brought to the floor at 12:51 P.M. Licensed Nurse 21 was observed verifying the tray cards and the food on the plate were correct. LN 21 was observed to only open the lid of a few trays, LN 21 did not open the lid on every tray to observe what was actually on the plate against the tray card. On 5/28/25 an interview was conducted with LN 21. LN 21 stated that she only lifted the lids on therapeutic diets that would prevent choking. LN 21 did not see what was on a regular tray. LN 21 did not verify for allergies or specific resident requests.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to cook food in a way to preserve the palatability of the food. As a result, residents may not want to eat the food served to them and have the potential for weight loss. Findings: 1. After the initial resident screening and confidential group interview it was determined there were resident complaints about the food served at the facility. The resident complaints included the food was served cold and did not taste good. During initial tour from 5/27/25 to 5/28/25 the following resident comments regarding food complaints were: On 5/27/25 at 08:28 A.M., during the initial screening Resident 36 stated the food does not taste good and looks cheap. Resident 56 stated food needs more variety food looks thrown together and worse on weekends the food issue has been brought up in resident council, but still feels food has not changed. On 5/27/25 at 8:47 A.M., Resident 6 stated the food was served cold at times. On 5/27/25 at 9:12 A.M., Resident 291 stated she did not eat the food served, the food tasted horrible, the presentation was horrible. Resident 291 stated she had thrown food away. Family brings her food in. On 5/27/25 at 9:27 A.M., Resident 38 stated the food was Disgusting, he doesn't eat the food, he gets something else. On 5/27/25 at 9:50 A.M., Resident 15 stated breakfast is always cold. The food combinations are weird. She stated she eats a lot of sandwiches. She stated her Diabetic doctor told her the biggest meal of the day should be breakfast, but here they just give her eggs. She complained the give her things she doesn't eat. On 5/27/25 at 10:24 A.M., Resident 23 stated the food is okay, but the portions to small, and the food can be cold when they get it. On 5/27/25 at 3:18 P.M., Resident 81 stated the food is not that great and he gets alternatives like a burger. On 5/28/25 at 08:15 A.M., Resident 20 stated food does not taste good and is cheap maybe they get the food from 99 cent store stated she gets a veggie or fruit plates due to food tasting bad (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the confidential group interview on 5/28/25 at 8:52 A.M., the residents stated we had issues about the food. The main issue was on the weekends when the Supervisor is not there. The sausage was cold, and cottage cheese not available. These resident complaints determined to the Survey team a test tray was needed to verify the temperatures and the taste of the food. On 2/28/25 a test tray was requested during the lunch tray line. According to the Menu, lunch was Roast Turkey with Savory Cream Sauce, Herb Roasted Red Potatoes, [NAME] Cauliflower and Peas, Fresh [NAME] Salad and [NAME]. The test tray was brought to the floor at 12:51 P.M., the temperatures were tested, and all meal items were tasted by the surveyor and the DSS for temperature and taste. The temperature of the food items was palatable, the Roast Turkey was tasteless the DSS agreed.

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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 interview and record review, the facility failed to ensure a licensed nurse (LN 37) documented a resident incident in the resident's clinical record for one of 24 sampled residents (48). As a result of this failure, it could not be determined if Resident 48 had fallen on 5/15/25. Findings: A review of Resident 48's admission Record indicated the resident was admitted on [DATE], with diagnoses that included S/P (status post) stroke, vascular dementia, (having to do with the blood vessels and circulation), and mild cognitive impairment. On 5/27/25 at 11:15 A.M., a telephone interview was conducted with Resident 48's Responsible Party (RP). The RP stated that she received a call from Resident 48 on 5/16/25 at 9:22 A.M. The RP stated that Resident 48 told her she had fallen and hit her head the night before. The RP stated two staff members helped get Resident 48 up. The RP stated she then spoke to the Assistant Director of Nursing (ADON) to report what Resident 48 had told her and the ADON stated there was no report that Resident 48 had fallen. On 5/27/25 at 2:02 P.M., an interview was conducted with Resident 48. Resident 48 stated on 5/15/25 she fell and hit the side table after losing balance and that two staff members helped her get up and sit in a chair. Resident 48 denied getting hurt. On 5/30/25 at 11:05 A.M., a telephone interview was conducted with LN 37. LN 37 stated around 8 or 9 P.M. she walked into Resident 48's room and saw her sitting on the floor near her bed. LN 37 stated that Resident 48 told her, I sat on the floor I don't have a chair to sit on. LN 37 stated the resident told her she decided to sit on the floor. LN 37 stated Resident 48 was assisted to a chair. On 5/30/25 at 11:25 A.M., an interview was conducted with LN 38. LN 38 stated she would question if Resident 48 was found sitting on the floor. LN 38 stated she would ask Resident 48 how she sat herself on the floor. LN 38 stated if she had seen Resident 48 on the floor, she would have done an assessment, and I would have documented. On 5/30/25 at 11:34 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for all nurses to document the incident even if a resident says they chose to sit on the floor. The DON stated if a resident was found on the floor it would need to be considered a fall. The DON stated when LN 37 found Resident 48 on the floor, it should have been documented. A review of the facility's policy titled Fall- Clinical Protocol, revised March 2018, did not provide guidance how to document an incident involving a resident found on the floor.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure there was a process for communicating hospice services for one of two residents reviewed for hospice services (Resident 5). This failure had the potential to put Resident 5 at risk for uncoordinated medical care and treatment between the facility and the hospice agency. Findings: Resident 5 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain) according to the facility's admission Record. A review of Resident 5's physician's orders (PO) in the Electronic Medical Record (EMR) was conducted on [DATE] at 10:27 A.M. The PO indicated, ADMIT TO ALL THINGS HOSPICE ON ROUTINE LEVEL OF CARE DIAGNOSIS: END STAGE STROKE . dated [DATE]. During a concurrent record review and interview on [DATE] at 9:15 A.M. with Licensed Nurse (LN) 1, LN 1 stated residents who were under hospice care had a hospice binder. LN 1 showed the hospice binder for Resident 5. LN 1 stated the form titled, PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT indicated, Effective Date of Certification: [DATE] to [DATE]. LN 1 stated the re-certification by the physician determined if Resident 5 was appropriate for hospice. LN 1 stated hospice staff should communicate with the facility if Resident 5 was still appropriate for hospice. LN 1 further stated that the facility's hospice coordinator was the Social Service Director (SSD). An interview on [DATE] AT 9:27 A.M. was conducted with the SSD. The SSD stated she coordinated care conferences and ensured that families signed a consent for hospice. The SSD stated she was not aware of Resident 5's physician certification that expired on [DATE]. The SSD stated Resident 5 was still under hospice care. During an interview with the Director of Nursing (DON) on [DATE] a 10:39 A.M., the DON stated hospice re-certification should be updated for the resident to receive hospice services because it determined if a resident should continue to meet the criteria for hospice. A review of the facility's policy and procedure (P&P) titled, Hospice Program, dated [DATE] was conducted. The P&P indicated, In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following .Determining the appropriate hospice plan of care .Changing the level of services provided .it is the responsibility of the facility .in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual's needs .Obtaining the following information from hospice .Physician certification and recertification of the terminal illness specific to each resident.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement (QAPI-plan developed by QAA to help improve conditions in the facility) Plan, trends found by surveyors during the recertification and relicensing survey concerning resident's nailcare and grooming, and the annual staff performance evaluations. This failure had the potential for the facility to overlook trends in resident care that might have affected residents' dignity and/or health and staff performance. Cross Reference: F677, F730 Findings: On 5/30/25 at 2 P.M., a concurrent interview with the Administrator (ADM) and the Director of Nursing (DON) and a review of QAPI program was conducted. The DON stated that the main areas that the QAPI team monitored were:1. Call lights, 2. Falls, and 3.Urinary Tract Infections (UTI). During the recertification and relicensing survey, deficient trends in the following areas were identified by the surveyor team:1. nail care and, 2.annual staff performance evaluations. The DON stated that these trends had not been identified by the QAA Committee and/or included in the QAPI plan. On 5/30/25 at 2:15 P.M., an interview with the DON was conducted. The DON stated that the expectation was the QAA Committee should have identified the trends that were identified by the survey team. In addition, the DON stated the deficient trends should have been included in the QAPI plan. The DON stated the importance of QAA Committee identifying deficient trends and including them in the QAPI plan was to promote the highest standard of care for their residents. Review of facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated February 2020, indicated .Implementation .2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components include .c. Identifying and prioritizing quality deficiencies . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Design and Scope, dated February 2020, indicated .1. The QAPI Program is designed to address all systems and practices in this facility that affect residents, including clinical care, quality of life, resident choice and safety . 4. The QAPI functions prioritize identified problem areas that are high risk, high volume, and/or problem prone .

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	05/30/2025

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 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 proper infection control practices by not discarding an unlabeled intravenous (IV) hydration bag and uncapped IV tubing that was left hanging in a residents room, for one of 5 sampled residents (Resident 2). This deficient practice placed facility residents at risk for exposure to infection and the spread of harmful bacteria. Findings: According to the Centers for Disease Control and Prevention (CDC) 2024, INJECTION SAFETY GUIDELINES, indicated, .IV bags, tubing and connectors are intended for single-patient use only and should be discarded immediately after use . A review of Resident 2's admission Record indicated Resident 2 was re-admitted to the facility on [DATE] with diagnoses which included a history of human immunodeficiency virus (HIV- a virus [tiny germ] that attacks the body's immune system). A record review of Resident 2's minimum data set (MDS-a federally mandated resident assessment tool) dated 4/3/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 11 points out of 15 possible points which indicated Resident 2 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 5/27/25 at 9:00 A.M., an observation and interview was conducted with Resident 2, in Resident 2's room. Resident 2 had two roommates (Resident 63 and 70) with beds divided by a curtain on both sides of his room. Resident 2 was in bed with an unlabeled 1000 ml (milliliters) IV hydration bag with approximately 800 ml remaining attached to an unlabeled IV tubing (uncapped) at his bedside on an IV pole. Resident 2 stated he did not have an IV line. On 5/27/25 at 2:42 P.M., an observation and interview was conducted with Resident 2, in Resident 2's room. Resident 2 was watching television (TV) in bed and stated the IV belonged to him. Resident 2's undated IV hydration bag, and unlabeled tubing (uncapped) was still hanging on the IV pole by his bedside. On 5/28/25 at 10:10 A.M., an observation was conducted in Resident 2's room. Resident 2 was asleep in bed. Resident 2's undated IV hydration bag, and unlabeled tubing (uncapped) was still hanging on the IV pole by his bedside On 5/29/25 at 8:50 A.M., an observation was conducted in Resident 2's room. Resident 2 was with an unidentified certified nursing assistant (CNA) that assisted Resident 2 with a clothing change. Resident 2's undated IV hydration bag, and unlabeled tubing (uncapped) was still hanging on the IV pole by his bedside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 9:26 A.M., an observation and interview was conducted with the Infection Control Prevention Nurse (ICPN), in Resident 2's room. The ICPN observed that Resident 2 had an undated IV hydration bag, and unlabeled tubing (uncapped) was still hanging on the IV pole by his bedside. The IPCN inspected Resident 2's upper extremities (arms and hands) and stated Resident 2 did not have an IV line/site. The ICPN stated that the IV hydration and tubing should have been labeled and discarded properly. The ICPN stated the IV pole needed to be wiped down and stored properly. The ICPN stated this was an infection control issue because we don't know who's IV hydration is that, and it's not labeled. The ICPN stated Resident 2 was immunocompromised (weak immune system) and could be mixed up and used by a wrong person to cause cross-contamination and infection control issues. On 5/29/25 at 9:47 A.M., an interview and record review was conducted with the ICPN, in the conference room. The ICPN stated Resident 2 had an order on 4/15/25 IV hydration .Sodium Chloride Solution 0.9% Use 100ml/hr [hour] intravenously [through the vein] one time a day for IV hydration for 1 Day Give 2L with Dextrose 5% . The ICPN stated she was unable to find orders for Resident 2's roommates for hydration orders. The ICPN stated that the IV hydration should have been removed from Resident 2's room and stated a confused resident can come in there and remove it put it in their mouth and you never know what can happen. The ICPN stated it was an infection control issue because the IV hydration was unlabeled and was not sure who it really belonged too, how long it had been there and could accidentally be used and potentially spread infection. On 5/30/25 at 3:23 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectations that room rounds should have noticed the IV hydration that was unlabeled be discarded immediately. The DON stated it should have been gone. The DON further stated this had additional safety and infection control issues. A review of the facility's policy and procedure titled POLICIES and PROCEDURES-INFECTION CONTROL revised, October 2018, did not give guidance for IV devices and equipment on proper storage and disposal.